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REPORT
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SOCIAL SECURITY DISABILITY BENEFITS REFORM ACT OF 1984

MARCH 14, 1984.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. ROSTENKOWSKI, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 3755]

[Including the cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3755) to amend title II of the Social Security Act to provide for reform in the disability determination process, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendment to the text of the bill is a complete substitute therefor and appears in italic type in the reported bill.

The title of the bill is amended to reflect the amendment to the text of the bill.

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SOCIAL SECURITY DISABILITY BENEFITS REFORM ACT OF 1984

I. Purpose and Scope

The committee's bill also amends Title II of the Social Security Act to provide for necessary reforms in the administration of the social security disability insurance program. The disability insurance program has attracted substantial Congressional attention over the last two years, primarily because of the numbers of beneficiaries whose benefits have been terminated. The review of current beneficiaries that has produced these terminations was mandated by Congress, but was accelerated in pace in March, 1981. There has been no suggestion that those receiving disability benefits should never be examined again, but the committee believes that the process over the last several years has resulted in erroneous termination of benefits for at least some people.

Therefore, the committee's bill addresses three major areas where reform appears to be most critically needed: in the standards for determining eligibility for disability benefits, both for new applicants and more particularly for current beneficiaries being reviewed; in the structure of the administrative process itself; and in the way in which the Social Security Adminstration makes disability policy, both on its own initiative and in conjunction with rulings of the Federal courts. There are in addition several miscellaneous provisions concerning payments to vocational rehabilitation agencies, publication of policies concerning consultative medical examinations, and establishment of new positions for social security staff attorneys.

The overall purpose of the bill is, first, to clarifly statutory guidelines for the determination process to insure that no beneficiary loses eligibility for benefits as a result of careless or arbitrary decision-making by the Federal government. Second, the bill is intended to provide a more humane and understandable application and appeal process for disability applicants and beneficiaries appealing termination of their benefits. Finally, the bill seeks to standardize the Social Security Administration's policy-making procedures through the notice and comment procedures of the Administrative Procedures Act, and to make those procedures conform with the standard practices of Federal law, through aquiescence in Federal Court of Appeals rulings.

The committee is deeply concerned about the erosion of public faith and confidence in the social security disability programs, and in the agency as part of the Federal government, that has occurred as a result of the changes in policies over the last several years. The guidelines established in this bill appear to the committee to be the best way to restore confidence in the program. The committee believes it is crucial to continued public support for the social security program as a whole for the public to understand that the program will be administered according to the law rather than by constantly shifting and possibly arbitrary policies.

II. Summary of Provisions

Standards of Disability

Standard of review for terminations of disability benefits (medical improvement)

Section 101 of the bill requires the continuation of benefits for those individuals whose conditions have not medically improved to the point of ability to perform SGA, with the following exceptions:

(a) benefits may be terminated if new evidence shows the beneficiary has benefited from advances in medical therapy or technology or from any vocational therapy to the point of ability to perform SGA; and

(b) benefits may be terminated if new evidence (including new diagnostic or evaluation techniques not available or used at the original determination) shows the impairment or impairments to be less severe than originally thought.

Section 101 also provides for termination of benefits whether or not the impairment has improved if the person is currently working at the substantial gainful activity (SGA) level, or if the prior determination of entitlement to benefits was either clearly erroneous at the time it was made, or was fraudulently obtained. SSA would be authorized to secure additional medical evidence to reconstruct initial decisions in cases where there is no medical evidence supporting the initial decision.

Study on evalution of pain

Section 102 requires the Secretary, in conjunction with the National Academy of Sciences, to conduct a study concerning the questions of using subjective evidence of pain in determining whether a person is under a disability, and the state of the art of preventing, reducing or coping with pain. A report is to be submitted to the Committee on Ways and Means and the Senate Committee on Finance by April 1, 1985.

Multiple impairments

Section 103 provides that in determinations of disability, the Secretary must consider the combined effect of all of an individual's impairments whether or not each or any impairment would alone be severe enough to qualify the person for benefits.

Disability Determination Process

Temporary moratorium on mental improvement reviews

Section 201 provides for a temporary delay on reviews of all mental impairment disabilities until the listings for mental impairments have been revised in consultation with the Advisory Council, and are published in final form in regulations. Regulations must be published no later than 9 months after the date of enactment. The delay also would be imposed on review of all CDI mental impairment cases after June 7, 1983.

Face-to-face evidentiary hearing

Section 202 provides for the implementation, no later than January 1, 1985, of face-to-face evidentiary interviews at the State agency level for medical termination cases. Under this provision, the State agency would send the beneficiary a preliminary notice of an unfavorable decision and the claimant would have 30 days in which to request a face-to-face meeting before a formal determination is made. The reconsideration level would be abolished for all initial CDI decisions completed after January 1, 1985.

Section 205 also requires the Secretary to initiate demonstration projects with respect to face-to-face evidentiary meetings at the initial level of State agency determination for new applicants and report to the Congress by April 1, 1984, and projects begun no later than July 1, 1984.

Payments of benefits during appeal

Section 203 provides on a permanent basis for the continuation of benefits during appeal in all CDI cases through the decision of the Administrative Law Judge. Where the ALJ's decision is adverse to the beneficiary, such benefit payments would be subject to recoupment as under present law. The provision also requires the Secretary to report to Congress on the impact of the provision by July 1, 1986.

Qualifications of medical professionals

Section 204 provides that no determination that a person is not under a disability be made with respect to mental impairments until a psychiatrist or psychologist employed by the State agency has completed the medical portion of the case review as well as the assessment of residual functional capacity.

Consultative examinations

Section 205 provides that regulations be promulgated regarding consultative examinations.

Miscellaneous Provisions

Application of uniform standards for disability determinations

Section 301 provides that the notice and comment provisions of Section 553 of the Administrative Procedures Act would apply to benefit programs under Title II. The provision leaves in place the existing exceptions in Section 553 of the APA referring to the issuance of interpretive rulings, as well as purely administrative procedures.

SSA compliance with certain Federal court decisions

Section 302 requires SSA to either apply the decisions of circuit courts of appeal to at least all beneficiaries residing within States within the circuit, or appeal the decision to the Supreme Court. This provision applies to circuit court opinions issued after the date of enactment as well as to those opinions which the Secretary still has the opportunity to appeal to the Supreme Court as of the date of enactment.

Payment from trust funds for costs of rehabilitation services

Section 303 repeals the requirement in those cases where there is a medical recovery that a disabled beneficiary must perform 9 months of SGA to qualify the vocational rehabilitation provider for reimbursement. In addition, payment for services to VR providers would be authorized for beneficiaries who without good cause refuse to continue to accept services or fail to cooperate with the rehabilitation process.

Advisory Council on Medical Aspects of Disability

Section 304 creates an Advisory Council on Medical Aspects of Disability composed of independent medical and vocational experts to provide advice and recommendations to the Secretary on disability standards, policies and procedures. The Council would include 10 members to be appointed by the Secretary (with the Commissioner of Social Security an ex officio member) and must include at least one psychiatrist, one rehabilitation psychologist and one medical social worker.

The Council would be authorized to periodically convene a larger representative group to assure the input of appropriate professional and consumer organizations, and would also be authorized to set up temporary short-term task forces to examine some specialized issues.

Section 304 further provides that the Council must be appointed no later than 60 days after the enactment (to assure the timely participation of the Council in the review of the mental impairment listings) and would expire on December 31, 1985.

Staff attorneys

Section 305 requires the Secretary of HHS to establish higher grade attorney positions to enable staff attorneys to achieve qualifying experience necessary to be appointed to ALJ positions.

Effective Date

Except as otherwise provided, these provisions will apply only with respect to cases involving disability deteminations pending in HHS or in court on or after the date of enactment.

Supplement Security Income (SSI) Disability Changes

The bill would make the same changes in the SSI disability program as the bill makes in the Social Security Disability Insurance program. In addition, the bill would extend for two and one-half years, through June 30, 1986, the temporary authority in section 1619 of the Social Security Act that provides for the continuation of SSI benefits and/or Medicaid for disabled recipients who are able to work in spite of their impairments. As related to the SSI disability program, the Advisory Council on Disability would also be required to consider alternative approaches to the use of work evaluation in determining eligibility for SSI disability benefits and to reexamine the definition of a successful rehabilitation of an SSI recipient to include the ability of the severely disabled to work in a sheltered environment and live independently.

III. Explanation of Provisions

A. Standards of disability (secs. 101–103 of the bill)

1. Overview

Sections 101–103 of the bill are designed to clarify the criteria that must be used in evaluating whether new applicants or current beneficiaries are disabled. The criteria laid out in present law are few, and brief:

(1) Disability is defined in Section 223(d)(1) of the Social Security Act as the inability to engage in any substantial gainful activity by reason of a medically determinable impairment which can be expected to result in death or to last at least 12 months;

(2) A second sentence added in 1967 expanded on this definition with respect to the type of work an individual must be unable to perform, i.e., not only his previous work but, considering his age, education and work experience, any work existing in the national economy, regardless of the existence of any specific job he might actually be hired for.

The committee does not intend to alter the current definition, which embodies the intent of Congress that only those who are verifiably unable to work are to be found eligible for disability benefits. However, it must be recognized that determining inability to work in each individual case must ultimately rest to some degree on the subjective judgment of the examiner.

In response to this inherent subjectivity, the disability determination process has developed into an elaborate system of checks and balances designed to prevent individual judgment from outweighing national policies defining who is totally disabled. The initial decision is made according to the submitted clinical findings, a deliberate paper decision that avoids as much as possible the personal influence of either the claimant or of his physician. The examiner's decision is then subject to several different kinds of reviews, through the quality assurance system and through a multilayered appeals system, in an attempt to ensure as much objectivity as possible in an inherently subjective decision.

The process each examiner follows in making disability decisions at the State agency level is known as the "sequential evaluation" process. After checking to see whether the claimant is currently working at the substantial gainful activity (SGA) level, the examiner next must determine whether the individual has a severe impairment; if he does not, the process goes no further.

SSA has been criticized for using the severe/non-severe test at this stage of the process as a way to terminate benefits, or deny initial applications without fully evaluating the person's real ability to work. This criticism has been particularly strong in the case of multiple impairments, because the regulations require that where the person has several impairments, of which none are severe, no disability can be found.

At this step and later on in the process, current policy is to take subjective evidence of pain into account only if objective medical data, such as laboratory tests and documented case history, show a specific impairment that can reasonably be concluded to be causing the pain. This policy is an attempt to ensure that a finding of dis-

ability is based only on "medically determinable" impairments, as required by the statutory definition, and to reduce the level of subjectivity inherent in the disability determination.

After finding that the person has a severe impairment, the examiner must determine whether that impairment matches the listings of disabling impairments or if, in combination with other less severe conditions, the total impairment equals the severity level in the listings (the "meets or equals" test). If it does not, the examiner must assess the person's "residual functional capacity"— ability to do either his past work or any other work in the national economy. SSA evaluates work capacity in a variety of ways, using all available evidence of work or productive activity in sheltered workshops, home settings and competitive work environments.

This evaluation is difficult to make for beneficiaries who have been receiving benefits for some time, particularly for those with mental impairments, whose illness may allow certain types of activity with limited circumstances, but possible not under the day to day pressure of a real job. SSA has been particularly criticized for not giving sufficient weight to the longitudinal medical and work history of mentally impaired claimants.

In summary, SSA's current policies for interpreting the definition of disability place a heavy emphasis on objective evidence to support a finding of disability. The sequential evaluation is designed to create a series of clear decisions for the examiner, particularly as to the severity of the impairment, which are to be made based only on verifiable clinical data, so that the subjectivity of the decision can be kept to a minimum.

While this process allows tighter control over the number of people allowed benefits, and therefore over program costs, it can result in denial of benefits for people who cannot be expected to work in view of their total condition. The definition of disability clearly states that benefits are to be paid to those who are unable to work because of severe impairment, not merely to those who meet a certain impairment level and incidentally are unable to work. The current procedures thus represent a compromise between complete evaluation of every individual's particular circumstances, on one hand, and, on the other, a completely objective "screen" of characteristics which must be satisfied in order to find a person disabled.

The committee wishes to reaffirm that the purpose of the disability insurance program is to provide benefits only for those who are unable to work. It is therefore completely appropriate for the Social Security Administration to periodically review beneficiaries who are not deemed to be permanently disabled, in order to ensure that the law is being carried out.

However, the committee is concerned that the consideration of eligibility for disability benefits be conducted using criteria that clearly reflect the intent of Congress that all those who are unable to work receive benefits. It is of particular concern that the Social Security Administration has been criticized for basing terminations of benefits solely and erroneously on the judgment that the person's medical impairment is "slight," according to very strict criteria, and is therefore not disabling, without making any further evaluation of the person's ability to work.

The committee believes that in the interests of reasonable administrative flexibility and efficiency, a determination that a person is not disabled may be based on a judgment that the person has no impairment, or that the impairment or combination of impairments are slight enough to warrant a presumption that the person's work ability is not seriously affected. The current "sequential evaluation process" allows such a determination, and the committee does not wish to eliminate or seriously impair use of that process. However, the committee notes that the Secretary has already planned to re-evaluate the current criteria for non-severe impairments, and urges that all due consideration be given to revising those criteria to reflect the real impact of impairments upon the ability to work.

It is also assumed that the length of time the beneficiary has been on the benefit rolls will be taken into account in assessing the person's residual functional capacity. The committee is concerned that the periodic review of beneficiaries who are over age 50, and who have been on the benefit rolls for some period of time, may result in termination of benefits for many in that age group who realistically cannot be expected to re-enter the work force given their age and length of time in receipt of benefits. Therefore, the committee directs the Secretary to re-evaluate the consideration given in the determination process for such beneficiaries to past relevant work, in order to ensure that older beneficiaries who have been receiving benefits for several years are carefully reviewed for realistic ability to work.

The committee is also concerned that the evaluation of the person's ability to work be made in a context that accurately reflects the capacity to work in a normal, competitive environment. Such an evaluation does not necessarily require a full "work evaluation" by a vocational expert in each case, although such evaluations are desirable and should be used wherever feasible where the additional information provided by such evaluations would be helpful in deciding close cases. The committee particularly urges that such evaluations should be used if at all possible in cases of mental impairment, where necessary to aid in determining eligibility in "borderline" cases, at the point in the sequential evaluation process where such evaluations would normally be done under current policy.

It is also important in such cases to evaluate the person's entire work history, rather than to examine only recent evidence of work activity, in order to determine whether the person can really engage in substantial gainful activity. The committee emphasizes that in any evaluation of work activity, the presence of work in a sheltered setting or workshop cannot in and of itself be used as conclusive evidence of ability to work at the substantial gainful activity level. Such work may be used in conjunction with other evidence that the beneficiary or claimant is not disabled, but benefits should not be denied simply because of sheltered work experience.

The committee emphasizes that the foregoing discussion does not constitute any change in the current definition of disability, but rather is a clarification of the intent of Congress that disability benefits should be granted to those who are unable to work because of a medically determinable impairment. Sections 101 and 103 of the bill provide statutory standards for determining disability: sec-

tion 101 establishes specific criteria for re-examination of current beneficiaries, while section 103 establishes criteria for multiple impairment cases both on initial application and on re-examination. Section 102 mandates a study and recommendations on the possible use of subjective evidence of pain in determinations of disability, with a view toward establishing standards in this area through legislation after consideration of the report. Taken together, these new statutory standards will provide much needed clarification of the law and of Congressional intent.

The committee also wishes to emphasize that the social security disability insurance program is a Federal social insurance program, fully funded by the disability insurance trust fund (including State and Federal administrative costs), and administered by the Social Security Administration. While disability determinations are made by State disability agencies under voluntary agreements with the Department of Health and Human Services, policies for making these evaluations are and must be established at the Federal level, for implementation on a nationwide basis.

The committee is aware of the actions several States have taken in response to conflicting interpretations of the applicable provisions of law relating to the termination of benefits—actions which, in effect, represent a failure to comply with certain policies issued by SSA. While such actions must be regarded as questionable, the current confusion that has given rise to them is understandable and creates a compelling need for congressional clarification. We believe the relevant issues would be resolved by this bill and that, as a result, the basis for any such actions would be eliminated.

The committee bill makes clear what the law is with regard to certain areas of contention such as the standard for medical improvement. With respect to the area that is not so clarified, i.e., the use of subjective evidence of pain in disability determinations, the intent of Congress is clear: upon receipt of information adequate to form a reasonable basis for legislating, Congress will enact a specific policy concerning pain; until that time, no change in policy by the Social Security Administration is mandated by this bill.

2. Standard of review for terminations of disability benefits (sec. 101 of the bill)

Section 101 of the bill provides for the first time in the social security statute a specific standard that must be met before a disability beneficiary can be found to be not disabled. SSA has always scheduled a certain percentage of disability beneficiaries for re-examination to determine whether they are still disabled. The statute contains no guidelines for appropriate criteria to govern these re-examinations, other than the definition of disability.

From 1969 to 1976, SSA's policy, established originally by an administrative law judge in one hearing, was to not terminate benefits for anyone whose condition had not improved since the initial determination of eligibility. This policy wass reversed in 1976 in internal SSA directives. Shortly thereafter, the Supreme Court, in *Matthews v. Eldridge,* agreed with the agency that the burden of proving continuing eligibility for benefits was on the beneficiary.

However, possible as a result of the pre-1975, a decreasing number of people seemed to be leaving the benefit rolls to return

to work in the 1970's—the rate of benefit terminations due to recovery or return to work fell from 32 percent per thousand beneficiaries in 1967 to 16 persons per thousand in 1975. As a result, Congressional interest was expressed, beginning in 1978, in requiring SSA to look at people who had been receiving benefits for a long time to see if they were still eligible. SSA's standard procedures for re-examining only a small number of beneficiaries seemed to be inadequate in light of the declining number of benefit terminations for return to work.

The 1980 Social Security Disability Amendments made a number of significant changes in disability program operations. Responding to the need for more effective management of the program, the legislation required a dramatic increase in the amount of management review and oversight of the program, with the objective of tightening central Federal control over State agency and ALJ decisions, and re-invigorating ongoing review of current beneficiaries. Of particular concern in connection with Section 901 of the bill was the provision requiring review at least once every three years of all beneficiaries not permanently dis bled, beginning in January, 1982.

However, the Department of Health and Human Services moved up the date of implementation of this provision, and accelerated the rate of review of current beneficiaries beyond the schedule required in the 1980 Amendments. Beginning in March 1981, SSA began sending out about three times the normal number of CDI cases: about 160,000 were done in FY 1981, 496,771 in FY 1982, and 640,000 were budgeted for FY 1983 prior to the Secretary's new initiative to slow down the review process announced in June, 1983.

The rate of terminations in these CDI cases at the initial level currently is about 45 percent, which is very close to the rate for reexaminations done in previous years. However, the types of cases being examined in the accelerated CDI process are different from the relative few cases SSA used to designate for re-examination because they had great potential for medical recovery.

The new caseload consists in large part of beneficiaries who were not scheduled for re-examination before, and who in many cases were found disabled several years ago, during and after the inauguration of the SSI program, when the decision criteria may have been less precise than those being used today. The magnitude of the CDI initiatives has meant that a very large number of the cases SSA considers were wrongly allowed (either by the original State examiner or by an ALJ overturning the State agency) are being re-examined for the first time since the policy change on medical improvement in 1976.

These re-evaluations are based on current standards and medical criteria which are in many cases more clear-cut and exact than the standards on which benefits were initially based, and reflect improvements in medical technology and treatment. Moreover, the overall "adjudicative climate" has been generally more rigorous than in earlier years, so that re-examined beneficiaries, now being looked at as if they are new applicants, will have more rigorous standards applied than in their initial determination. For example, beneficiaries who originally were allowed benefits because their combination of impairments roughly approximated the level re-

quired by the medical listings ("equals the listings"), are now more likely to be evaluated according to whether their impairment matches the medical criteria ("meets the listings"), which are themselves different from the criteria in 1970.

It has been alleged that the agency, particularly in mental impairment cases, has focused too heavily on the severity of the medical condition without making an adequate evaluation of the beneficiary's ability to work, with the result that benefits have been terminated for many people who cannot function in a work environment. These policies seem to have been in effect well before the inauguration of the accelerated review in 1981, but the combination of an apparently more restrictive policy and reviews of large numbers of beneficiaries have resulted in widespread complaints about SSA's procedures.

These policies have come under severe criticism in Federal courts, particularly in the Ninth Circuit Court of Appeals which has ruled twice that SSA must demonstrate either medical improvement or (in the later ruling) clear and specific error in the original award, in order to terminate disability benefits. Similar "medical improvement" standards have been declared in other circuit courts as well, and an increasing number of State governors have declared those judgements to be binding on ALJ's and State adjudicators in opposition to Federal policy guidelines.

In summary, the re-examination of large numbers of current disability beneficiaries has resulted in termination of benefits for many beneficiaries whose medical condition has not changed substantially since they were allowed benefits. Medical impairments are being closely examined to determine whether they meet today's standards—if the impairment is now judged to be not severe, the person's benefits are terminated, whether or not the impairment is any different from when the person was first allowed. The primary issue therefore is whether a person's benefits should be terminated because standards of disability have changed since the individual was first allowed benefits, so that he is judged able to work under current criteria even though his medical condition has not improved.

The committee recognizes that the problems with the current review have arisen, at least in part, because the criteria for termination of benefits as a result of review were left unstated in the law. SSA has therefore had wide discretion to apply whatever standards it deemed appropriate—and since the standards of the current program apparently are stricter than those in the past, applying today's standards has meant eliminating benefits for many more beneficiaries than was anticipated when the 1980 Amendments were enacted.

Therefore, section 101 of the bill establishes a clear "medical improvement" standard that creates a category of beneficiaries who, because their medical conditions have not improved, are presumed to be unable to work and who therefore must continue to receive benefits. This standard contains several important exceptions which would allow termination of benefits even where the beneficiary's medical condition has not improved: where the beneficiary is performing substantial gainful activity, where medical or rehabilitation techniques allow the person to work despite his un-

changed condition, where the original decision was in error, or was fraudulent, or where new or improved diagnostic techniques or evaluations reveal that the impairment is less disabling than originally thought.

The committee believes these exceptions address several legitimate concerns: that benefits which were improperly allowed originally should not be continued; and that the documented effects of medical or vocational therapy on an individual's ability to perform SGA, and the result of a reassessment of the severity of an individual's impairment based on the application of new or improved diagnostic or evaluative techniques need to be taken fully into account in making continuing disability determinations. The committee emphasizes, however, that the application of these exceptions is contingent on the satisfaction of specified requirements relating to documentation, the acquisition of appropriate medical and vocational evidence and the use of specified techniques or procedures. Thus, with respect to the effect of medical or vocational therapy on an individual's ability to perform SGA, the exception would be applicable only if it is demonstrated, on the basis of new medical evidence and a new assessment of the individual's residual functional capacity (RFC), that the individual has been the recipient of services which reflect advances in medical therapy or technology (or the recipient of any vocational therapy) which has had the effect of restoring the individual's ability to engage in SGA.

Similarly rigorous requirements must be satisfied with respect to the use of the exception relating to the results obtained from the application of new or improved diagnostic or evaluative techniques which may disclose that the individual's impairment is less disabling than originally thought at the time of the prior determination (for example, the individual has the ability to do his previous work, that is, usual work or other past work). The committee recognizes that there may be some cases in which the prior decision that the individual was disabled was based, in part, on an assessment of residual functional capacity that was either improperly or inadequately documented. While it might be argued that in such cases a finding of clear error ought to be made, it is not intended that the standard of "clearly erroneous" be loosely applied to encompass inadequate development of a case. Moreover, the cases involved here do not represent "erroneous determinations"; rather, they reflect decisions properly made in accordance with the state of the art at the time the decisions were made and in accordance with the administrative procedures in place at that time. The fact is, however, that changing methodologies and advances in medical and vocational diagnostic and evaluative techniques have given rise to improved methods for documenting and evaluating medical evidence, RFC, and vocational factors. Where such methods, properly used, permit the development of more accurate, objective and valid results, they should not be ignored.

The committee intends that where SSA uses new or improved evaluation techniques to determine and document an individual's ability or inability to work, and where this new determination shows that an individual is not as disabled as initially considered (for example, the individual can do his previous work), such evidence may serve as the basis for a finding under this section that

the individual is not disabled within the meaning of Title II of the Social Security Act.

The committee expects that this exception will be carefully applied and that any determinations made in accordance with this provision will be fully documented, accurate and consistent with objective medical and vocational findings. Since these cases may involve individuals who have been receiving disability benefits in good faith, the committee re-emphasizes here that it expects the Secretary to re-evaluate the consideration given in the continuing disability process to factors such as age and duration in benefit status. Nonetheless, when appropriately and responsibly applied, this exception is available to assure the equitable attainment of the objectives of the program.

The committee is aware that in some cases adjudicated in prior years all the medical information relevant to the initial decision may not still be in the beneficiary's file and that such a situation would preclude the possibility of making an objective finding with respect to a change in the severity of the beneficiary's impairment. In such cases, SSA would be authorized to secure such medical information as may be necessary to fully reconstruct the medical records and data that were utilized in making the initial decision. The committee emphasizes, however, that the inability to reconstruct such records and data cannot serve, in and of itself, as a basis for a determination that there has been medical improvement. Such a conclusion may be reached only if the records applicable to the initial decision have been fully reconstructed and the prior and current medical evidence discloses that there has in fact been medical improvement.

3. Study concerning evaluation of pain (sec. 102 of the bill)

The social security statute currently provides no guidance on the use of allegations of pain by the claimant in the disability determination process. Because the definition of disability states that inability to work must be "by reason of a medically determinable impairment", the Social Security Administration has allowed allegations of pain to be used only if a specific physical impairment exists to which the pain can be reasonably attributed.

However, many claimants allege disability primarily or substantially as a result of disabling pain that cannot be specifically attributed to a physical condition. Because the law itself is not explicit, allowance decisions at the ALJ and Federal court levels have not infrequently depended heavily on this kind of subjective evidence. Almost every circuit court of appeals has ruled at some point over the last ten years that eligibility should be based on subjective evidence of pain, at least in cases where it corroborated by testimony of other witnesses.

The committee is concerned that a fragmented standard is now in effect for using subjective evidence of pain, depending on whether the beneficary has pursued his claim through the ALJ or district court level. While it may well be the case that pain in and of itself, regardless of its cause, can result in inability to work, there is apparently still no way to verify the existence of such pain through objective medical testing.

The committee is therefore reluctant at this time to allow determinations of disability to be based on such subjective criteria. There is plainly a critical need for a clear legislative policy, to be applied to all cases on a nationwide basis; it is not appropriate for the Federal courts to establish policy on such an issue simply because the statute is insufficiently specific. However, the committee cannot, at this time, mandate such a policy, simply because there is not enough information about the impact this kind of change would have on the types of cases that would be allowed and on the costs to the disability program.

Therefore, section 102 of the bill requires the Secretary in conjunction with the National Academy of Sciences, to conduct a study on the question of using subjective evidence of pain in determining disability, and on the question of the state of the art of preventing, reducing or coping with pain, and to report to the Congress by April 1, 1985 on the results of the study. It is anticipated that at that time, Congress will be able to develop a satisfactory statutory standard.

The committee also directs the Secretary to conduct such studies as are necessary to obtain complete information and statistics on both the fiscal costs and administrative feasibility of eliminating the 5-month waiting period for disability benefits for persons diagnosed by their physicians as terminally ill with less than 12 months to live. The results of such studies shall be presented to the Congress no later than October 1, 1984.

4. Multiple impairments (sec. 103 of the bill)

Under current law, the first step in the sequential evaluation process through which the disability determination is made is to determine whether the applicant has a severe impairment. If SSA determines that a claimant's impairment is not severe, the consideration of the claim ends at that point. In cases where a person has several impairments, none of which meet the standard for "severe", he is judged not disabled, without any further evaluation of the cumulative impact of his impairments on his ability to work.

The committee believes that this does not represent a realistic policy with respect to persons with several impairments which may in many cases interact and effectively eliminate the person's ability to work. While it is clear that the determination of disability must be based on the existence of a medically determinable impairment, there are plainly many cases where the total effect of a number of different conditions can safely be characterized as disabling, even if each by itself would not be. Section 103 of the bill therefore requires that in determining whether an individual's physical or mental impairment or impairments are so severe as to be disabling, SSA must consider the combined effect of all the individual's impairments without regard to whether any individual impairment considered separately would be considered severe.

B. Disability determination process (secs. 201–205 of the bill)

1. Moratorium on mental impairment reviews (sec. 201 of the bill)

Serious questions have been raised by Federal courts, professionals in the fields of psychiatry and vocational counseling and the General Accounting Office about the adequacy of SSA's Listing of Mental Impairments and the appropriateness of SSA's current methods for assessing residual functional capacity and predicting ability to work in individuals with mental impairments. While the validity of all these criticisms may be subject to some debate, it is clear that in many cases individuals have been improperly denied benefits. Moreover, the Secretary has determined that a full scale re-evaluation of the Listings and current procedures is necessary and, on her own motion, has imposed a moratorium on reviews of mental impairment cases classified as functional psychotic disorders. However, the moratorium imposed by the Secretary does not include all mental impairment cases that will be affected by changes in the listings and procedures, does not provide a precise timetable for the review and resolution of the pertinent issues and does not stipulate how the results of these changes are to be subsequently implemented.

The committee agrees that a moratorium of the kind imposed by the Secretary is warranted. However, the committee is concerned about the need to establish clear guidelines with respect to the review process, the timeframe for conducting the re-evaluation and procedures for the disposition of cases, including new applications and prior CDI's in the categories affected by the moratorium. The purpose of section 201 is to provide these guidelines.

Under section 201 a temporary delay would be imposed on reviews of all mental impairment cases until the Secretary revises the criteria embodied under the category "Mental Disorders" in the "Listing of Impairments." The revised listings and procedures for assessment of residual functional capacity are to be designed so as to realistically evaluate the ability of a mentally impaired individual to engage in substantial gainful activity in a competitive environment. Regulations establishing such reviewed criteria and listings are to be published no later than 9 months after the enactment. Moreover, the Secretary is required to conduct this re-evaluation and to prepare the appropriate regulations in consultation with the Advisory Council on Medical Aspects of Disability (created under section 304 of the bill).

This delay of reviews would apply to all CDIs of mental impairment cases upon which a timely appeal was pending on or after June 7, 1983 or on which no initial decision has been rendered as of the date of enactment, unless the individual is engaged in substantial gainful activity or fraud is involved.

Initial cases denied during the moratorium period are to be reviewed by the Secretary as soon as feasible after the new criteria are established, and those with mental impairments who were denied benefits or had their benefits terminated between March 1, 1981 and the date of enactment will have their cases reopened as of the most recent prior determination if they reapply within one

year. Benefits would be paid as of the date of reapplication but the individual's insured status would thus be protected.

The committee is cognizant of the fact that revision of the listings in the mental impairment area could potentially result in an increase in the cost of the disability program. For that reason, the committee intends to monitor closely the cost effects of these revisions and directs the Secretary to report to the Committee on Ways and Means and the Senate Committee on Finance on the cost effects of any proposed changes in the listings 30 days in advance of the implementation of the regulations.

2. Face-to-face hearings in State disability determination agencies (sec. 202 of the bill)

Decisions as to whether or not an individual is disabled are made by 54 State disability agencies under agreements with SSA. These decisions may be appealed. Currently a disability claim or a CDI may go through five or more decision levels:

(1) The initial decision by the State agency, which if adverse can be appealed to

(2) the reconsideration level, also conducted by the State agency, which if adverse can be appealed to

(3) the Federal administrative law judge hearing, followed by, if adverse,

(4) an appeals council review; and finally

(5) if all prior decisions are adverse, the claimant can file an appeal in the Federal court system.

Under present law, the Federal Administrative Law Judge (ALJ) is the first level at which the disabled individual meets face-to-face with a decisionmaker. Initial interviews are conducted in SSA district or branch offices (of which there are about 1300) when the individual first applies or is first called in for a CDI, but no decisions are rendered there.

Even though no decisions are rendered in the social security district office, the committee recognizes the importance of the initial interview a CDI beneficiary or new applicant receives there. The district office has traditionally played a major role in assuring a full explanation of the program, of the individual's rights, the procedures involved, and in providing assistance to the individual in pursuing his or her claim.

P.L. 97–455 mandated that by January 1, 1984, individuals whose benefits are terminated due to a medical review (CDI) must be given the opportunity to have a face-to-face evidentiary hearing at the reconsideration level conducted either by the Secretary or the State agency. Although it may be necessary for logistical reasons for the Secretary to implement this provision in many areas of the country through the use of SSA hearings officers, the committee would encourage the Secretary to offer State agencies the option to conduct these face-to-face hearings. Since, under the provisions of the committee's bills, this reconsideration hearing would be only a temporary transitional procedure which would be phased out as the State agencies implement a face-to-face interview at the initial State agency decision level, State agencies could acquire valuable experience in conducting the transitional reconsideration hearing.

There is virtually unanimous agreement about the desirability of providing for a face-to-face meeting between the disability beneficiary and the administrative decisionmaker. The committee believes that such a meeting at the initial stage in the adjudicative process would permit State agency disability examiners to better assess the individual's residual functional capacity and assure that all relevant medical and vocational information has been obtained. Moreover, an interview at the initial State agency level, rather than at some later stage, would both simplify and expedite the decisionmaking process.

Consequently, section 202 provides for the implementation, no later than January 1, 1985, of face-to-face evidentiary interviews by all State disability agencies at the initial decision level for all medical termination cases. Under this provision, the State agency would send the beneficiary a preliminary notice of an unfavorable decision and the claimant would have 30 days in which to request a face-to-face meeting before a formal determination is made. The present reconsideration level would be abolished upon implementation of the State interviews. The committee emphasizes that where it is possible it would prefer that this provision be implemented earlier than January 1, 1985, and that where this occurs the transitional reconsideration hearings would be terminated.

The committee also endorses the concept of instituting face-to-face hearings at the initial, State level, and of abolishing the reconsideration level, for initial claims as well as CDI review cases. However, it is recognized that this procedure would be a complicated and major change for the program necessitating further study and preparatory administrative planning. As a result, section 905 also requires the Secretary to initiate demonstration projects with respect to face-to-face evidentiary meetings at the initial level of State agency determinations for new applicants and requires the Secretary to report to the Congress by April 1, 1985, on these projects. These projects must be conducted in a minimum of five States with the participating States to be selected no later than January 1, 1984. Where the projects are initiated, the reconsideration level would be eliminated.

The committee emphasizes that, where feasible, these demonstration projects should be implemented prior to the dates in the bill and notes that some States have expressed a strong interest in testing out this procedure. Since the committee is concerned that there be a full and cooperative effort made to implement and carry out all phases of a face-to-face interview in initial cases, the committee believes it would be appropriate to use these particular States in the demonstration projects.

3. Payment of benefits during appeal (sec. 203 of the bill)

P.L. 97-455, passed by Congress in December 1982, included a provision to allow beneficiaries whose benefits had been ceased because of a medical review of their eligibility to elect to continue receiving benefits until an ALJ has rendered a decision on the case. If the case is denied, then the benefits, except for Medicare, are subject to recoupment (subject to the hardship waiver standards already in law). This provision, however, was adopted on a temporary basis only—until further consideration could be given to the CDI

issue in the 98th Congress. Thus, under present law, no extended payment can be made after June 1984 and the provision applies only to cessations occurring before October 1, 1983. For cessations after that date the program will revert to prior law which provided benefits for the month of cessation and two additional months. Since January approximately 113,000 individuals have elected to continue benefit payments during appeal.

Section 203 provides on a permanent basis for the continuation of benefits during appeal in all CDI cases through the decision of the Administrative Law Judge. Where the ALJ's decision is adverse to the beneficiary, such benefit payments would be subject to recoupment as under present law. The Secretary also must report to the committee on Ways and Means and the Committee on Finance by July 1, 1986, on the impact of this provision on expenditures from the social security and Medicare trust funds and the rate of appeals to ALJs. The committee believes, based on the experience under the present temporary provision, that providing for continuation of payments during appeal helps considerably to ease the severe financial and emotional hardships that would otherwise be suffered by disabled persons.

In addition, it is recognized that beneficiaries may be reluctant to elect to receive continued benefit payments for fear of not being able to repay the benefits provided if the decision of the Administrative Law Judge is unfavorable. The committee intends that at the time beneficiaries are given the opportunity to make this election they be informed that, in the event of an unfavorable determination, they might be eligible for a waiver or for a long-term repayment plan. The committee further intends that the Secretary take into account individual circumstances in making a determination as to whether or not to waive the overpayment.

4. Qualifications of medical professionals (sec. 204 of the bill)

A shortage of qualified medical personnel has been a chronic problem in the social security disability program. Knowledgeable medical consultation is necessary for accurate decisions, and particular concerns have been raised that in the area of mental impairments a general medical knowledge is often not sufficient for a full evaluation of an individual's claim. The committee notes that through the encouragement of the Social Security Administration almost all State agencies now have staff psychiatrists available.

Section 204 requires that where there is an unfavorable decision in a mental impairment case, a qualified psychiatrist or psychologist must complete the medical portion and the residual functional capacity assessment of the determination. The committee believes that this requirement will help assure an accurate determination of the individual's capacity for substantial gainful activity.

The committee would also encourage the Social Security Administration to urge States to secure qualified specialists in other areas of impairments and to examine methods (such as referrals to nearby States or to the SSA central office) for providing consultation with specialists where that would be helpful but is not locally available. The committee notes that requiring States to hire physicians in all specialties would be costly and in some States impossible. Nonetheless, the committee believes efforts should be made, to

the extent feasible, to provide disability examiners with the expert consultation of specialists wherever that would be helpful in making an accurate decision.

In this and other areas the committee notes that efforts to gather every piece of evidence must be balanced against the time and resources required to do so. If the disability judgment takes too long or becomes too fraught with complicated procedures for gathering evidence it would be criticized on those grounds. Indeed, some courts have interposed time limits on how long the agency can spend in reaching a decision. Given the already substantial administrative costs of the program and the constraints imposed by individual States on securing additional personnel, the availability of resources is also a real consideration since imposing requirements for which there are not adequate resources generally causes additional disruption of the program—the opposite effect from that intended.

Nevertheless, concerns have been expressed that in an effort to process cases in an expeditious manner, procedures have been followed by SSA which inhibit the full development of medical and other evidence and which made it more difficult for disabled claimants fully to state their case.

The committee emphasizes the need to examine all relevant evidence in making a disability determination and the need to actively seek and pay particular attention to evidence from treating physicians, especially in chronic illnesses. SSA and State agency personnel share an obligation to assist the claimant in understanding the process and securing necessary medical data. The committee, therefore, requests that the Secretary report to the Congress on the current use of home visits by agency personnel and on whether there are other instances where a home visit would not now occur but which might be constructive in providing the agency with full information on a claimant.

Similarly, the committee is concerned that hearings locations (and face-to-face interview locations) be accessible to beneficiaries. Such offices should be located in buildings fully accessible to the handicapped; funding for medical evidence and travel should be provided, and the Social Security Administration should re-examine the current requirement that a beneficiary must travel at least 75 miles in order to qualify for travel reimbursement as this standard may be inappropriate in many locations in this country.

5. Regulatory standards for consultative examinations (sec. 205 of the bill)

Consultative examinations are medical examinations purchased by the agency from physicans outside the agency to secure medical information necessary to make a determination or to check conflicting evidence. Many concerns have been raised about the improper or generally unsupervised use of CE's and SSA has taken several steps to tighten up procedures in this area and particularly to restrict the use of doctors providing CE's on a volume basis (volume providers).

The committee is pleased to note that efforts are being made to provide more direction in the use of consultative examinations and would encourage SSA to redouble its efforts to secure reasonable

fee structures for consultative examinations so that dependency on volume providers can be reduced. The committee also believes, however, that concerns about the use of consultative examinations would be lessened if policies now in effect with respect to consultative examinations (or any subsequent policies that may be developed in this area) were embodied in regulations. Section 205, therefore, requires that the Secretary promulgate such policies in regulations. Since the purpose of this provision is only to assure that the policies are published in regulations there is no intent or implication that any new claims or pending cases involving consultative examinations be delayed until the regulations are published. On the contrary, it is the committee's intent that such cases will continue to be processed and adjudicated as under present law.

The committee also notes that questions have been raised about SSA's application of the trial work provision of present law. In order to eliminate any possible misunderstanding or confusion about the intent of this provision, the committee reaffirms that recency of work and sustained work over several consecutive months is necessary for an individual to meet trial work conditions.

C. Miscellaneous provisions (secs. 301–305 of the bill)

1. Uniform standards for disability determinations (sec. 301 of the bill)

Section 553 of the Administration Procedure Act of 1946 established basic requirements for informal rulemaking, the process by which most regulations today are promulgated. This section requires general notice of proposed rulemaking to be published in the *Federal Register*, and an opportunity for public comment during a period of at least thirty days prior to the effective date of the rule. There are general exceptions to these requirements for interpretative rules, statements of policy, and rules of agency procedure, organization or practice, and where the agency for good cause finds the notice and comment procedures impractical or contrary to the public interest.

Social security benefits are not covered under Section 553 by virtue of an exception in Section 553(a)(2): "a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts." This exception was part of the original APA, which was enacted at a time when there were very few Federal benefit programs: the social security disability and Medicare programs did not exist, and requirements for old age and survivor benefits were fairly explicit in the statute. In 1971 then-Secretary of HEW (now HHS) Elliot Richardson issued a statement placing all HEW programs voluntarily under the APA rule-making requirements.

However, SSA has continued to issue, as do other agencies such as the Internal Revenue Service, other policy statements, notably Social Security Rulings and the disability claims manuals (POMS), which are supposed to contain only clarification and interpretation of the policy contained in regulations. In addition, it has been alleged that real operating policy often develops as a result of State disability examiner reaction to return of specific allowance decisions deemed incorrect by SSA's Federal quality assurance review-

ers. None of these sources of policy are open to public notice or comment.

The Bellmon Report on the hearings and appeals process, mandated by the 1980 Disability Amendments, found wide discrepancies in standards applied by the administrative law judges who are bound by the statute and regulations, as opposed to those applied by the State agencies who are bound by the POMS. This discrepancy may be a major reason for the high reversal rate of State agency denials at the ALJ level (standing at around 55 percent currently). As a result of this report, and the even higher reversal rate for CDI cases, there has been considerable pressure for uniform criteria at all levels of adjudication. SSA's response to this pressure was to begin incorporating the POMS into Social Security Rulings, which by regulation (20CFR 422.8) are to be relied upon as precedents in cases where the facts are essentially similar by ALJ's as well as State agencies.

The original exception for social security to Section 553 notice and comment requirements appears to have been more an accident of history than deliberate Congressional intent concerning all social security programs. When the APA was enacted, the disability program did not yet exist, and there were as yet very few social security beneficiaries of any sort.

Elimination of the APA exception for benefits has been recommended by the American Bar Association, and such a change has been incorporated in H.R. 2327, currently under consideration by the Judiciary Committee (a similar provision was previously approved by the Senate). There appears to be widespread agreement concerning eliminating just the exemption in 553(a)(2) for public benefits. There appear to be considerably greater complications in any changes to section 553(b)(A) which allows interpretive statements to be issued without public notice and comments. The Judiciary bill provision for limiting the exemption in 553(b)(A) for interpretive rules has been the subject of extensive debate for some time, and the bill retains the good cause exception in 553(b)(B).

The committee believes that it is appropriate for changes in policies that affect whether or not people receive disability benefits to be published in regulations allowing for public participation in the process. The policy decisions that must be made concerning disability determinations are far more complex than most policies in the old age and survivor programs, for one major reason: the determination of ability to work is an inherently difficult eligibility decision, while eligibility for retirement benefits depends on factors of age, quarters of coverage, and current earnings that are relatively easily determined.

However, the agency should also have sufficient flexibility to respond to changes in conditions quickly, and to issue administrative guidance to State agencies on a timely basis. There is clearly an appropriate role for issuance of informal policy clarification through rulings or other informal vehicles, and the committee has no wish to deprive the Social Security Administration of this ability.

Therefore, section 301 of the bill requires that the notice and comment provisions concerning issuance of regulations of section 553(a)(2) of the Administrative Procedures Act be applied to benefit

programs under Title II. The provision does not affect the application of the exception in section 553 allowing informal policy clarifications to be issued through non-regulatory statements.

The committee emphasizes that the intent of the provision is to provide uniform standards for decision-making at all levels of the disability determination process, through the normal channels of rule-making that allow some degree of public participation in the process. In order to allow SSA some degree of flexibility in administering the extremely complex disability program, the bill allows the current practice of issuing Social Security Rulings to continue. However, it cannot be too strongly emphasized that the intent of the provision in eliminating the first exception is that all policy that substantially affects the determination of eligibility must be the same for all levels—State agency through administrative law judge—and must be issued through regulations.

This provision does not address directly the problem of informal policy direction given to State agencies through the quality assurance process. It may be difficult to prevent returns of cases to the State agency from having an effect on overall adjudicative policy, particularly as the agency begins to review sixty-five percent of all favorable decisions. However, the committee intends Section 301 of this bill to produce uniform policy at all levels arrived at through processes open to public scrutiny. It is therefore expected that the Social Security Administration will take all steps necessary to limit the influence of quality assurance systems on day to day operations and policy of State agencies.

The committee is also aware of the grey area that exists between issues clearly having substantial policy impact that plainly belong in regulations, and issues clearly minor, administrative or merely clarifying that plainly belong in informal policy statements. It will be necessary, therefore, for the committee to closely monitor. SSA's activities with respect to this provision to assure that misunderstandings do not arise and that the desired ends are achieved. All administrative law relies heavily on the presumption that agencies will perform their duties in good faith, and the committee is, to a certain degree, relying on the expectation of good faith efforts by the agency to promulgate uniform standards through the regulatory process. If after some period of experience, it is found that this section has not had the desired effect of producing uniforms standards, further measures will be considered.

2. SSA compliance with certain Federal court decisions (sec. 302 of the bill)

Under the Federal judicial system, decisions by a circuit Court of Appeals are considered the "law of the circuit," and constitute binding case law to be followed by all district courts in that circuit. In general, if two circuits rule differently on a particular issue, the Supreme Court will review the issue to settle the dispute. The application of Supreme Court decisions to executive branch policies is virtually undisputed: if a particular policy is found unconstitutional, or contrary to the statute, that decision is binding on the agency. The appropriate application of circuit and district court decisions to agency policies is not as clear-cut.

Claimants for benefits under the Social Security Act may appeal State agency denials through several layers of administrative appeal, up through the appeals council. A claimant who wishes to continue to pursue appeal may next turn to the Federal district court with jurisdiction over his or her claim. The district court reviews the record as compiled by the agency to determine whether substantial evidence existed for the agency's decision. The district court's review is not a trial de novo, but rather is limited to a consideration of the pleadings and the transcript of the proceedings at the ALJ hearing. If the district court finds substantial evidence existed to support the agency's decision to deny benefits, a claimant may appeal the decision to the circuit court with jurisdiction, and ultimately petition the Supreme Court for certiorari.

Appeals of the agency's determinations to the Federal district courts are occurring with much greater frequency in recent years, imposing a workload burden on some district courts. Between 1955 and 1970, the total number of disability appeals filed with the Federal district courts was about 10,000 cases. In 1982 alone, nearly 13,000 disabliity cases were appealed to the district courts. The large increase in Federal court litigation on social security matters may be partly responsible for the present tension between SSA and the lower Federal courts.

Most disability cases decided in the Federal courts have little value as precedent for SSA decisions, since most reversals of agency determinations rest on the lack of substantial evidence for the agency's position. However, in many instances the court's opinion sets forth a statutory interpretation contrary to that of the agency, in the traditional manner in which Federal courts establish a rule of law, which is intended to be binding on the agency in later cases concerning the same issue. Circuit courts of appeals decisions in such cases have been issued with increasing frequency in recent years, with the clear expectation of the court that SSA would abide by its interpretation as would normally be the case with rulings having precedent as law within the circuit.

The Social Security Administration does not follow U.S. Courts of appeals decisions with which it disagrees, either nationwide or within the circuit of the ruling. While the agency does obey the court's ruling in the particular case being adjudicated, the interpretation of law from the court is not considered binding by the agency either for State disability agency operations or for Federal social security offices.

Moreover, the agency frequently does not appeal district court or circuit court opinions with which it disagrees. This practice ensures that the Supreme Court will not have the opportunity to review the issue and render a decision with which the agency would be compelled to comply. Social security ALJ's are not able to follow court of appeals decisions as precedent if the Supreme Court does not make a ruling or if the agency does not incorporate the circuit court's decision in social security rulings or regulations, which is most often the case in decisions SSA disagrees with.

SSA has been criticized for this policy, both by outside experts and Federal judges, on the grounds that it undermines the structure of Federal law, and in essence allows SSA to overrule the legal judgment of the Federal courts by administrative inaction.

SSA defends its policy on the grounds that a Federal benefits program should be administered uniformly on a national basis. It should be noted that in a brief before the Supreme Court in *Califano* v. *Yamasaki* (1979) the brief for petitioner Secretary Califano stated the following:

> When a statutory or constitutional issue is decided adversely to the Secretary in the course of judicial review obtained by an individual claimant, the Secretary will either appeal or abide by the unfavorable ruling. Repetitious litigation will thus not be necessary in order to establish a general legal principle applicable beyond the confines of a particular case. *Stare decisis* will impel the Secretary to follow statutory or constitutional decisions within the jurisdiction of the courts having rendered them.

This statement is in marked contrast to the repeated instances brought to the committee's attention of SSA's non-acquiescence policy, summed up in the following statement from the Associate Commissioner for Hearings and Appeals issued to Social Security ALJ's in January, 1982:

> The Federal courts do not run SSA's programs, and [SSA's adjudicators] are responsible for applying the Secretary's policies and guidelines regardless of court decisions below the level of the Supreme Court. (Social Security memorandum to its Administrative Law Judges)

Since 1978, there have arisen numerous cases in which circuit courts of appeals have ruled on issues where the Title II or XVI statute is unspecific or silent, most notably the issues of use of allegations of pain in disability determinations, and of whether a beneficiary whose condition has not medically improved can be found not disabled. Every circuit court of appeals in the country with the exception of the D.C. circuit has ruled that subjective evidence of pain must be allowed in finding claimants eligible for benefits. Several circuits, including the Ninth Circuit in two separate opinions, have ruled that SSA must show that a beneficiary has medically improved before ruling him no longer disabled. In all of these cases, SSA has not applied the court interpretation of the statute beyond the litigated case, and has not pursued an appeal to the Supreme Court.

The committee is concerned about the result of this non-acquiescence policy for claimants, the courts and SSA. First, while it is clearly of utmost importance that a Federal program be administered according to uniform, Federal standards, it is not clear that SSA's non-acquiscence policy substantially achieves that end. In fact, under the current policy, distinctions exist *within* circuits between policies applied to those claimants who pursue their claims to the appeals court level, and those who cannot. Such a difference will be particulary significant in those circuits where a class action suit applying to several thousand claimants is successful.

The committee is most concerned about the impact of this policy on beneficiaries and claimants, and on their relationship to the social security program. If a circuit court rules on a given issue such as medical improvement, it is a foregone conclusion that sub-

sequent appeals to that court on that issue will be successful. By refusing to apply the circuit court ruling, SSA forces beneficiaries and applicants to re-litigate the same issue over and over again in the circuit, even though the agency is certain to lose each case.

The committee can find no reason grounded in sensible public policy to force beneficiaries to sue in order to obtain what has been declared by the Federal court as justice in a particular area. Such a policy creates a wholly undesirable distinction between those beneficiaries with the resources and fortitude to pursue their claims, and those who accept the government's original denial in good faith or because they lack the means to appeal their case. The strength of the social security program has always rested on the public perception that the agency's mission is to provide benefits to all those entitled to them, without undue delay or bureaucratic barriers. The increasingly adversarial character of the process for becoming eligible for disability benefits, and especially for retaining eligibility, does immeasurable harm to the public's trust in the social security program and in government as a whole.

The committee is also concerned about the increasing number and intensity of confrontations between the agency and the courts as SSA refuses to apply circuit court opinions. The Ninth Circuit court recently characterized the Secretary's defense of her non-acquiescence policy as "far from persuasive." The opinion goes on to state:

> . . . other circuits that have considered the question have already rejected the Secretary's argument that a Federal agency can legitimately ignore Federal appeals court precedents. See, e.g., Jones & Laughlin Steel Corp. v. Marshall, 636 F.2d 32, 33 (3d Cir. 1980); ITT World Communications v. FCC, 635 F.2d 32, 43 (2d Cir. 1980); Ithaca College v. NLRB, 623 F.2d 224, 228–29 (2d Cir.), cert. denied, 449 U.S. 975 (1980); Mary Thompson Hospital, Inc. v. NLRB, 621 F.2d 858, 864 (7th Cir. 1980); Allegheny General Hospital v. NLRB, 608 F.2d 965, 970 (3d Cir. 1979). Moreover, the cases cited by the Secretary to support her position appear to be inapposite. In short, our review of the relevant case law indicates that there is little chance that the Secretary will succeed in her argument that non-acquiescence is a legitimate policy, or, to put it more precisely, that she will persuade us that there is a strong probability that the plaintiffs would ultimately prevail on this fundamental issue.

While the issue of the constitutionality of the non-acquiscence policy may be in doubt, the undesirable consequences of escalating hostility between the Federal courts and the agency are clear. The committee sees no compelling reason why the Social Security Administration's interpretation of the statute, particularly in issues where the definitions are not specific or are completely silent on the issue, should be automatically considered superior to that of the Federal court.

SSA's reasons for the current policy appear to be based largely on the desire for consistent national administration of the program. It is also clear that Federal courts may frequently hand

down decisions expanding agency policies in directions the agency and Congress may not wish applied on a national or regional basis. Since the guiding principle for Federal courts is the Constitution and the law, policy considerations such as cost constraints may play less of a role than they appropriately do in Congressional deliberations

In such instances, however, the committee strongly believes that Congress' judgment as to the appropriate policy should prevail. If the Federal circuit courts hand down decisions that appear detrimental to the purposes or operation of the program, either the Supreme Court should be given the opportunity to make a determination that remedies the situation, or Congress may well have to clarify the law. In such cases, Congress might reasonably expect the agency to propose appropriate remedial legislation. Short of legislative changes, however, the committee sees no reason to allow SSA to ignore the law as determined in each circuit by the highest Federal court simply because the administrators view the Federal court's decision as mistaken.

Therefore, Section 302 of the bill requires the Social Security Administration to either apply the decisions of circuit courts of appeal to at least all beneficiaries residing within States within the circuit, or appeal the decision to the Supreme Court. This provision applies to circuit court opinions issued after the date of enactment as well as to those opinions which the Secretary still has the opportunity to appeal to the Supreme Court as of the date of enactment.

3. Payment from trust funds for costs of rehabilitation services (sec. 303 of the bill)

Prior to P.L. 97-35 (1981 Reconciliation Act), up to 1.5% of the total amount of disability benefits could be transferred from the trust funds for payment of vocational rehabilitation services for SSDI beneficiaries. In FY 1980 the amount transferred was $110 million (the amounts transferred generally were well below the 1.5% ceiling). An additional $50 million in general revenue funds were expended for SSI disability recipients. A benefit cost study completed by the Social Security Administration found that in 1975 between $1.39 and $2.72 savings accrued to the social security trust fund for every $1.00 spent in this program.

P.L. 96-265 (the 1980 Disability Amendments) included a provision that DI and SSI benefits could continue even after medical recovery until the individual completed a vocational rehabilitation program in which he was participating provided he had not been expected to recover when he entered the program and provided the program would increase the possibility of the individual permanently leaving the rolls.

P.L. 97-35 abolished the general DI trust fund program and further provided the State VR agencies could be reimbursed only for the costs of services to beneficiaries that result in the beneficiary's performance of SGA (substantial gainful activity) for a continuous period of at least 9 months. Trust fund expenditures for FY 1982 were about $2 million and have remained under $10 million each year since.

Section 303 provides assurance to vocational rehabilitation service providers that they will be reimbursed for services rendered to

participants in the medical recovery program (Sec. 301 of P.L. 96-265) be removing the restriction added by P.L. 97-35 that reimbursement could occur only where the beneficiary had performed nine months of SGA and by adding a provision that reimbursement will occur where the beneficiary without good cause refuses to accept or fails to cooperate with services in such a way as to preclude successful rehabilitation.

The committee is concerned that provision of vocational rehabilitation services to social security beneficiaries be improved. Therefore, it directs the Advisory Council on Medical Aspects of Disability to examine the whole area of the availability of vocational rehabilitation services for social security disability beneficiaries with particular attention to the following issues: How to assure that beneficiaries are referred for services in the most expeditious manner; whether the Secretary should contract directly with public and private non-profit providers of services, including rehabilitation facilities; how to provide adequate incentives for State and non-profit organizations to participate in programs available to social security beneficiaries; and what types of services should be provided to people whose SSDI benefits are terminated as a result of a continuing disability investigation and how best to provide such services.

The committee also reaffirms the congressional intent that payment for eligible vocational rehabilitation services, based on reasonable estimates, be made to service providers in advance.

4. Advisory Council on Medical Aspects of Disability (sec. 304 of the bill)

At a time when several major aspects of the social security disability program are to be re-evaluated and potentially revised in the light of advances in medical and vocational diagnostic and therapeutic techniques, the committee believes it is desirable to assure that the Secretary has ready access to the advice and recommendations of medical and vocational professionals. Thus, the bill creates a temporary Advisory Council (which would expire on December 31, 1985) consisting of medical, psychological and vocational experts to provide the necessary advice and recommendations to the Secretary on disability standards, policies and procedures. To assure the input of appropriate professional and consumer organizations, the Council would be authorized to periodically convene a larger representative group and to set up temporary short-term task forces to examine particular specialized issues. Under the bill, the Council's recommendations to the Secretary would be communicated to the Congress in SSA's currently required annual report to the Congress on the status of the disability program.

Of most immediate concern to the committee is the participation of the council in the required review of the mental impairment listings. The bill provides that the Council must be appointed within 60 days after enactment to assure the timely participation of the Council in this review.

The committee believes that the Council can also productively contribute to the re-examination of a number of other critical issues in the program. Section 304, for example, specifically directs the Council to examine and provide recommendations with respect

to the question of requiring the involvement of appropriate medical specialists services; i.e., how best to assure their availability and effective delivery to disabled persons. Moreover, it is expected that the Council will participate in the assessment of possible policy changes affecting medical aspects of the program, particularly any changes that might be considered with respect to the evaluation of pain. Because the Advisory Council will be considering issues concerning the delivery of vocational rehabilitation services, work evaluation and appropriate procedures and criteria for such services and activities, it is expected that among those chosen to be included on the council will be those with expertise in administering State and private non-profit vocational rehabilitation programs.

5. Qualifying experience for appointment of certain staff attorneys to administrative law judge positions (sec. 305 of the bill)

To qualify for an ALJ appointment, one must be an attorney with at least seven years of experience participating in formal cases at regulatory agencies, or in the preparation and trial of cases in courts of record, or in certain other legal work described in announcement. At least two of those years must be in the field of administrative law or in certain activities regarding hearings or the trial of court cases. At lease one year of qualifying experience must have been at the GS–14 level in the Federal service, or at a comparable level of difficulty and responsibility in other employment. The highest grade available for staff attorneys who assist social security ALJs is the GS–12 level. Social security ALJ appointments carry a lifetime tenure at a GS–15 level.

The committee shares the concerns repeatedly expressed by OPM and SSA about the difficulty of finding qualified candidates for social security ALJ positions. Staff attorneys who work with social security ALJs are readily familiar with the social security program and with adequate training represent a potential pool of candidates for ALJ positions.

Section 305 requires the Secretary to establish a sufficient number of attorney advisor positions at GS–13 or GS–14 levels to ensure adequate career advancement opportunity for attorneys employed by SSA, and to assign duties and responsibilities to enable individuals in these positions to achieve qualifying experience for an ALJ appointment. The committee notes that the Committee on Post Office and Civil Service has expressed support for this amendment.

D. SSI provisions

1. Extension of the section 1619 program for the SSI disabled who perform substantial gainful activity despite severe medical impairment (sec. 306 of the bill)

Section 306 extends for two and one-half years, through June 30, 1986, the temporary authority contained in section 1619 of the Social Security Act that provides for the continuation of SSI benefits and/or Medicaid for disabled recipients who are able to work despite the continuation of their impairments.

Section 306 also requires the dissemination of information about the section 1619 program to the disabled and staff of various agencies and organizations.

Prior to mid 1985, HHS would compile information on the characteristics of section 1619 recipients including health services usage, impairments, and other information intended to be used in making recommendations regarding the continuation and/or needed modification in section 1619.

Section 1619 was enacted as part of the Disability Amendments of 1980 and was intended to lessen the work disincentives for SSI disabled recipients who, under prior law, risked the loss of SSI and Medicaid when they increase their work effort and earnings in spite of the continuation of their disability.

Section 1619(a) of the SSI law provides that an individual who loses eligibility for SSI because he or she works and demonstrates the ability to perform SGA, but who continues to have a disabling impairment, may become eligible for special SSI benefits until their countable income reaches the SSI income disregard "breakeven point". People who receive the special SSI benefits continue to be eligible for Medicaid on the same basis as regular SSI recipients.

Under section 1619(b), an individual can continue to be eligible for Medicaid even if their earnings have taken them past the SSI income disregard "breakeven point." This special eligibility status, under which the individual is considered a blind or disabled individual receiving SSI benefits for purposes of Medicaid eligibility, applies as long as the individual: (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing to work by the termination of eligibility for Medicaid services; and (4) has earnings that are not sufficient to provide a reasonable equivalent of the benefits (SSI, State supplementary payments, and Medicaid) which would be available if he or she did not have those earnings.

Section 1619 was enacted to be effective for three years with the expectation that information would be gathered regarding the characteristics of those who benefit from section 1619 and the impact of such a program on reducing the work disincentives for the disabled under the SSI disability program. The most recent information available to the Committee from the Social Security Administration shows that in December 1982, 287 SSI recipients were receiving benefits under the provisions of Section 1619(a) and 5,600 former SSI recipients were retaining eligibility for Medicaid under section 1619(b). Approximately one-half of section 1619 recipients are under age 30 compared to only 16 percent of all SSI disabled adult recipients.

The Administration has agreed to an extension of section 1619 with the understanding that more complete data will be collected and available by mid 1985 for further evaluation of the program. The Administration has agreed to collect data regarding the characteristics of the individuals benefiting from these provisions, the effects on work effort, and, in the case of continued Medicaid coverage, the types of health care services utilized and their costs. Some of the specific areas that should be studied are: the types of impairments of the affected individuals; the types of income available to

these individuals—earned and unearned; the movement of individuals from one eligibility status to another; the kinds of health services used and the offsets to costs due to employer-related health insurance and other third-party resources. It is recognized that the collection and analysis of these data require the participation and cooperation of the Social Security administration for matters involving eligibility, characteristics, and work incentives; the Health Care Financing Administration for matters relating to Medicaid costs and utilization; and the State agencies administering the Medicaid programs for providing Medicaid data in their files; and the Committee expects such cooperation.

This provision to continue the section 1619 program, also directs the Secretary of Health and Human Services and the Secretary of the Department of Education to develop and disseminate information and establish training programs for staff personnel, with respect to the potential availability of benefits and services for disabled individuals under the provisions of section 1619. At Committee hearings held in California and Washington, D.C. and from reports from the disabled and rehabilitation and social services agencies, the Committee found a lack of awareness or knowledge of the section 1619 program.

As stated in testimony at the hearings, "Getting information out to the disabled community is no simple task. It requires the best effort of the Social Security Administration and the cooperative efforts of disability organizations, rehabilitation agencies, and other groups concerned with disability." However, as was also stated in hearings by a disabled individual, who did not utilize the option available under section 1619 because the District office staff of the Social Security Administration did not inform her about section 1619. " In order for SSI recipients like me to use these work incentive options, we need to be aware of how they can help us attain our employment goals without jeopardizing our health and wellbeing."

The provision provides that the Social Security Administration would be responsible for training programs for their staff in the District offices. The Social Security Administration would also be responsible for making a concerted effort to inform SSI disability applicants and recipients about the provisions of Section 1619. The amendment also mandates that the Department of Education, intended to be carried out primarily through the Rehabilitation Services Administration, to also be involved in getting information out to the State Vocational Rehabilitation agencies. In addition, working with and through such agencies, the information is also to be made available to the other public and private rehabilitation and social service agencies in the States and to the various organizations of and representing the disabled.

The section 1619 program is intended to be a tool which can be used by those agencies and organizations responsible for enabling the disabled to improve their capabilities to increase their level of self support, to live independently or to work in a sheltered environment. Therefore, the Committee is concerned that unless there is a greatly increased effort to get information out to a broad range of individuals and organizations that many disabled individuals will not be made aware of this attempt by Congress to eliminate

the work disincentives for those disabled who are able to work in spite of their impairment.

In a related matter, the Committee is concerned that the Administration is counting toward the "trial work period" any month in which the disabled is earning over $75 a month in a sheltered workshop. The Committee feels that the trial work period is to be used to, in effect, test the individuals ability to be eventually employed in a sheltered work shop should not be counted toward the "trial work period" months.

At the hearing held by the Subcommittee on Public Assistance and Unemployment Compensation regarding the extension of the section 1619 program, the following case examples were presented as to the impact of the section 1619 program:

> In order for this committee to realize the impact of section 1619, a description of two cases should provide you with information that will, hopefully, assist in your decision. The first is a 26 year old woman who is a quadriplegic and requires an attendant to assist with her personal care and home care needs such as bathing, dressing, grooming, cooking, shopping and other needs. Vocational rehabilitation helped her complete a college program, providing funds for training and for attendant care. After graduating from college, she obtained full time employment as a computer operator with earnings of $650 a month. Although she briefly received attendant care under a State medical program, she eventually was told she must either quit working or lose her eligibility. Since she was unable to pay this herself, she decided to quit working.
>
> The second case is a personal friend on SSI who has overcome great barriers with his disability. He is a quadriplegic who has no use of his legs, right arm and limited mobility with his left arm. He obtained his Bachelor's degree in 1975 with assistance from the Vocational Rehabilitation Program. He then moved to Minnesota to continue with graduate school. Since no Medicaid Title 19 was available to assist with Attendant Care costs, he was forced into institutional care. In 1978, he was able to move out into the community of Minnesota due to the Attendant Care Program funded through the Federal and State Governments.
>
> While finishing his education, he began full time work for a Rehabilitation Center, but after the nine month Trial Work Period, he would lose SSI status and, therefore, eligibility for Medicaid Title XIX and Social Services Title XX which paid for his Attendant Care. Ultimately, he had to quit an excellent position at the conclusion of his Trial Work Period or be forced to return to a life of dependency and institutional care. The cost of such care far exceeds the cost of continuing to live independently in the community with partial benefits.
>
> Passage of the 1980 Social Security Disability Amendment, which included the provisions in Section 1619, changed the picture dramatically for these two individuals.

In 1981, my friend was able to obtain employment at another Rehabilitation Center in Minneapolis. He has retained Medicaid Title XIX and Social Services Title XX, and receives some SSI payments which make it possible to pay the additional expenses of living independently.

Today, he holds a new position with a private non-profit consulting firm that provides technical assistance on disability awareness to corporations and businesses in the private sector. The firm sponsors seminars that show supervisors and management how to work and communicate with disabled employees, thus, creating increased employment opportunities for persons with disabilities.

If SSI Special Benefits Amendment (Section 1619) is not continued, he will again be forced to quit his job in order to avoid institutional care, since he cannot afford the cost of attendant services without public assistance while engaged in employment.

2. SSI disability program work evaluation and rehabilitation study

Section 307 would require the Advisory Council on the Medical Aspects of Disability to also study the following issues related to the SSI Disability program:

Consideration of alternative approaches to the use of work evaluation related to determination of eligibility for SSI disability benefit including: criteria for referral to work evaluation; relationship to rehabilitation potential and training; and appropriateness of providing stipends during extended work evaluation; and

Reexamining the definition of a successful rehabilitation of an SSI disabled recipient to include the ability of the severely disabled to work in a sheltered environment and live independently.

Work evaluation for purpose of the study would include determining an individual's: work activity capabilities; work activity limitations; rehabilitation potential; ability of the mentally impaired to cope with a competitive work environment; and needed modifications in the work setting to enable the individual to work.

Section 307 of the bill would require the Advisory Council on the Medical Aspects of Disability to consider alternative approaches to the use of work evaluation related to the SSI disability program. Such consideration by the Council should include examining proposals presented to the Committee on Ways and Means by various individuals and organizations with expertise in the area of work evaluation and rehabilitation.

The SSI program for the disabled grew out of the formerly State administered program for the disabled and was not an offshoot of the Social Security Disability Insurance program. Under the pre-SSI program the definition of disability was set by each State under some rather general Federal statutory and regulatory language.

While there is a common definition for disability for the Disability Insurance program and the SSI program, there are a number of very significant differences between the two programs and the

characteristics of the recipients of disability insurance and SSI disability recipients. These differences are critical when evaluating an individual's potential for employment and when determining the approach which should be taken both in determining eligibility for disability benefits and the approach to rehabilitation activities for such recipients. In addition, it needs to be recognized that Congress has defined a unique function for the SSI disability under the section 1619 program by providing ongoing income support and medical services under Medicaid for those disabled who have disabling impairments but who wish to have some level of employment in spite of their impairment.

The following chart compares some selected characteristics of the two programs and of the recipients of benefits under the two programs.

Comparison of Selected Characteristics of the SSI Disability Program and the Social Security Disability Program and a Comparison of Selected Characteristics of Recipients of Disability and SSI Disability Benefits

Social Security Disability Insurance	SSI Disability Program
A. NON-DISABILITY BASIS FOR ELIGIBILITY	
A. Disability Insurance provides benefits for workers who are "insured for disability" and their dependents.	A. Eligibility for and the amount of SSI benefits for a disabled or blind individual is not related to whether the individual has earned social security coverage or to the level of an individual's previous earnings. Cash assistance for the disabled and blind under SSI is provided only to those who, in addition to meeting the disability criteria, have income and resources low enough to meet the eligibility standards. While approximately 34 percent of the disabled receiving SSI disability benefits also receive DI benefits, only one-third of those or 12 percent are DI recipients on the basis of their own work history.
B. IMPACT OF EARNINGS BY RECIPIENTS ON AMOUNTS OF BENEFITS	
B. Earnings by DI recipients below the SGA earnings test level does not reduce the amount of DI benefits paid to the recipient.	B. SSI recipients have a $1 reduction in SSI benefits for every $2 in earnings in excess of $65 a month ($85 a month if no other income).
C. MAJOR DISABLING DIAGNOSIS	
C. Approximately 12 percent of the DI recipients are eligible of the basis of mental impairments; circulatory disorders account for 29 percent of the disabling impairment; and skeletal-muscular impairments account for 19 percent.	C. Approximately 40 percent of the SSI disabled are eligible on the basis of mental impairments. Approximately 20 percent are on the basis of circulatory disorders.

COMPARISON OF SELECTED CHARACTERISTICS OF THE SSI DISABILITY PROGRAM AND THE SOCIAL SECURITY DISABILITY PROGRAM AND A COMPARISON OF SELECTED CHARACTERISTICS OF RECIPIENTS OF DISABILITY AND SSI DISABILITY BENEFITS—CONTINUED

Social Security Disability Insurance	SSI Disability Program
D. AGE OF RECIPIENTS	
D. 7. percent are under age 30 and 66 percent of the DI population in ages 50 through 64 years of age.	D. 24 percent are under age 30 of the SSI disabled population ages 18–64 and 66 percent are ages 50–64 of the SSI disabled population ages 18–64.
E. SEX OF RECIPIENTS	
E. 70 percent male and 30 percent female.	E. 40 percent male and 60 percent female.

At the August 3rd hearing of the Subcommittee on Public Assistance and Unemployment Compensation, testimony was presented on behalf of the State of Michigan's Interagency Task Force on Disability by the Director of the Michigan Department of Mental Health. The Michigan Task Force, which consists of professional staff from the State Disability Determination Service, the State vocational rehabilitation service agency, the State department of Mental Health, Department of Social Services and other state agencies made recommendations based on a broad view of the role of Federal and state government's responsibilities as related to the disabled. In describing the proposed Michigan model, as to the recommended use to be made of work evaluation, the Task Force representative contended that long term cost savings will accrue to the Federal government and to States through the use of work evaluations and vocational rehabilitation in selected cases.

The testimony stated that:

> The relationship between multiple impairments and work ability or the relationship between residual capacity and work ability should be reliably documented. This documentation should involve the application of accepted techniques by a trained counselor who can become personally familiar with the claimant. This vocational documentation should become a part of the objective information which is reviewed in deciding whether disability benefits should be awarded. In this way, and only in this way, can ALJ's and disability examiners render uniform, reliable decisions based on objective assessments of a whole person—including equally-weighted medical and functional documentation

In directing the Advisory council to consider alternative approaches to work evaluation, section 307 defines work evaluation as follows:

> For purposes of this section, "work evaluation" includes (with respect to any individual) a determination of (a) such individual's (b) the work activities or types of work activity for which such individual's skills are insufficient or inadequate, (c) the work activities or types of work activity for which such individual might potentially be trained or rehabilitated, (d) the length of time for which such individual is capable of sustaining work (including, in the case of the mentally impaired, the ability to cope with the stress of competitive work), and (e) any modifications which may be necessary, in work activities for which such individual might be trained or rehabilitated, in order to enable him or her to perform such activities.

The reason that such an approach is recommended, especially as related to the SSI program, is that most SSI applicants have had a very tenuous or non-existent connection to the work force. Therefore, if work evaluation is used only to determine eligibility for income assistance, the result could be to deny the individual the opportunity to gain access to those rehabilitation services which can enable an individual to lessen his or her dependency. On the other hand, if work evaluation is not used to accurately gauge, to the extent possible, the individual's limitations on being able to work at a substantially gainful wage level then the individual may be denied that financial assistance to which he or she is entitled and which is reflective of his or her very limited capacity to be self-sufficient.

This approach to work evaluation is illustrated in the following excerpt from the State of Michigan testimony:

> In the model, I propose all individuals who pass through the screening criteria would be determined "presumptively disabled" and would be granted SSI benefits for up to six months, during which time additional vocational information would be acquired. These presumptive beneficiaries would be referred to state Vocational Rehabilitation agencies for a work evaluation to determine their potential for either gainful employment or for the development of skills needed for successful sheltered employment.
>
> Results for work evaluations would be transmitted to examiners within the State DDS to be used in their final determinations of disability. If, based on comprehensive work evaluations, the claimant is found capable of SGA, the DDS would deny the individual as non-disabled. If the person is found to have no potential for SGA, and it is determined that further efforts at rehabilitation would not be effective (due to impairment), the case would be approved for SSI and SSDI benefits. In such cases, involvement in a sheltered workshop on an ongoing basis might be appropriate, with benefit levels reduced by the amount of sheltered workshop income. Finally, if the person is found to be potentially employable, SSI benefits would be granted during the person's progression (through rehabilitation) to more independent work settings. This latter possibility, involving training and rehabilitation, would vary

in length depending on individual competencies. At all points in a work rehabilitation plan, disability benefits would be reduced by the amount of income earned, case management responsibility would be vested in the rehabilitation agency (with DDS diarying claimant progress).

The amendment suggests the evaluation of the concept of "stipends" to be provided to those in the work evaluation process. The purpose here is to recognize that those individuals with such borderline ability to be self supporting must have a subsistence level of income while in an extended work evaluation.

Section 307 also requires the Advisory Council to examine the criteria for assessing whether a recipient of SSI disability benefits will benefit from rehabilitation services. Specifically, the amendment provides that such an examination will consider whether such criteria should include not only whether an individual will be able to engage in substantial gainful activity but also whether such services can be expected to improve the individual's functioning so that he or she will be able to live independently or work in a sheltered environment.

Unlike the Disability Insurance program, earned income below the Substantial Gainful Activity earnings test of $300 a month received by SSI disability recipients does result in a savings to the SSI program. SSI benefits are reduced $1 for every $2 of earnings after the initial disregard of the first $85 a month for individuals with no other income. Therefore, rehabilitation services and training will have a savings to the SSI program even if the earnings of an SSI disability recipient does not reach the SGA earnings test of $300 a month.

In addition, at the income level provided under the SSI program even an additional small increment of income from sheltered employment can make a significant difference between marginal subsistence and some degree of independence, improved quality of life, and self-esteem which such earnings can provide.

3. SSI conforming amendments

Included in the bill as reported by the Committee are provisions to make generally the same changes in the SSI statute (Title XVI of the Social Security Act) as are made in the Disability Insurance program under Title II of the Social Security Act. The provisions also ensure applicability to the SSI Disability program of certain temporary provisions in Title IX affecting the Disability Insurance program. These include, for example, making applicable to the SSI program required studies related to pain and the moratorium in the reviews of the mentally impaired.

E. Effective date (sec. 308 of the bill)

Except as otherwise provided, these provisions of the bill would apply with respect to cases involving only disability determinations pending in HHS or in court on or after the date of enactment.

IV. Cost Estimates; Vote of the Committee and Other Matters to be Discussed Under the Rules of the House

In compliance with clause (2)(l)(2)(B) of rule XI of the Rules of the House of Representatives, the Committee states that the bill was approved by voice vote.

In compliance with clause (2)(l)(3)(A) of rule IX, the Committee reports that the need for legislation to provide for necessary reforms in the administration of the disability insurance program has been confirmed by oversight hearings conducted by the Committee's Subcommittee on Social Security.

In compliance with clause (2)(l)(3)(D) of rule XI, the Committee states that no oversight findings or recommendations have been submitted to the Committee by the Committee on Government Operations with respect to the subject matter contained in the bill.

In compliance with clause (2)(l)(4) of rule XI, the Committee estimates that enactment of the bill will not create inflationary pressures on the national economy.

In compliance with clause (2)(l)(3)(B) of rule XI, the Committee states that discussion of budgetary authority is contained in the report of the Congressional Budget Office.

In compliance with clause 7(a) of rule XI, relative to the budget effect of the bill, the Committee states that it agrees with the estimates of the Congressional Budget Office.

A. Cost estimates prepared by Congressional Budget Office

In compliance with clause (2)(l)(3)(C) of rule XI, the Committee states that the Congressional Budget Office has examined the bill, as reported by the Committee, and has submitted the following statement.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., March 14, 1984.

Hon. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed the provisions of H.R. 3755, the Social Security Disability Benefits Reform Act of 1984, as ordered reported by the Committee on Ways and Means on March 14, 1984. We have not received a recent copy of this bill. On the advice of your staff, however, we have prepared the attached cost estimate assuming the provisions in this bill are identical to those in Title IX of H.R. 4170, as ordered reported by the Committee on March 1, 1984.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

RUDOLPH G. PENNER, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 3755.
2. Bill title: Social Security Disability Benefits Reform Act of 1984.

3. Bill status: As ordered reported by the White House Ways and Means Committee on March 14, 1984.

4. Bill purpose: To amend Title II of the Social Security Act to provide for reform of the disability determination process.

5. Estimated cost to the Federal Government: The following table shows the estimated costs of this bill to the federal government. These estimates assume an enactment date of May 1, 1984. The estimate was prepared without a draft of the bill, but it is assumed that the provisions will be identical to those in Title IX of H.R. 4170, as ordered reported by the Committee on Ways and Means. March 1, 1984.

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF H.R. 3755

[By fiscal year, in millions of dollars]

Budget function	1984	1985	1986	1987	1988	1989
Function 550:[1]						
Budget authority	3	10	11	7	8	9
Estimated outlays	3	10	11	7	8	9
Function 570:						
Budget authority	1	28	28	20	19	9
Estimated outlays	7	73	86	83	77	59
Function 650:						
Budget authority	−1	−15	−35	−55	−75	−105
Estimated outlays	46	238	268	268	271	195
Function 600:[1]						
Budget authority	1	7	10	11	13	14
Estimated outlays	1	7	10	11	13	14
Total costs of savings:						
Budget authority	4	30	14	−17	−35	−73
Estimated outlays	57	328	375	369	369	277

[1] Funding for entitlements that requires further appropriations action.

Basis for estimate

This bill would change the disability process for those individuals who undergo continuing disability reviews (CDR's) and for those who apply for Disability Insurance (DI) and Supplemental Security Income (SSI) benefits. Historically, continuing disability reviews have been performed on medical diaried cases—those cases which the Social Security Administration (SSA) evaluates as having some chance of medical improvement within a specific length of time. In 1981, SSA began an intensified process of periodically reviewing all cases on the rolls not considered permanently disabled.

It is difficult to project the costs of the provisions in this bill for several reasons. First, there are little data available on the characteristics of the people who have been terminated from the DI rolls as a result of the continuing disability investigations. Second, the Administration has recently changed some of its policies regarding the review process, and it is unknown how these changes will affect the number of terminations from the program. Finally, the language of the provisions allows for various interpretations which would affect costs. This estimate is based on the interpretations of the bill provided by Committee staff.

This cost estimate assumes that 110,000 medical diary reviews would be performed annually. The number of periodic reviews is

assumed to decline from less than 300,000 in 1984 to 120,000 in 1989, as the percentage of beneficiaries already reviewed increases. Approximately 45 percent of the medical diary reviews are estimated to result in initial terminations of benefit payments, but CBO estimates about 57 percent of these beneficiaries would have their benefits restored after appeals are reviewed. For periodic reviews, the percentage of initial terminations is projected to decline from 40 percent in 1984 to 20 percent in 1989. About 55 percent of those initially terminated from the rolls in periodic reviews are estimated to have their benefits restored in the appeal process.

There are also costs to the Medicare program which would result from a larger number of recipients continuing to receive DI benefits because most DI beneficiaries also receive assistance from the Medicare program in either the Hospital Insurance (HI) or Supplemental Medical Insurance (SMI) components of that program. Estimates of these costs are based on the average number of disabled beneficiaries receiving HI and SMI and the average benefit payments for these programs. There are also costs to the Medicaid program because SSI beneficiaries generally receive Medicaid.

Table 2 displays CBO's outlay estimates by section of the bill. Following the table is a description of the methodology used for the estimates of the outlays for each section listed in Table 2.

Termination of benefits based on medical improvement

This provision would require SSA, with some exceptions, to provide "substantial evidence" that a beneficiary's disability has medically improved before SSA can terminate benefits as a result of a CDR. The bill does not specify what substantial evidence would be. Currently SSA is not required to prove medical improvement before terminating benefits.

This provision would affect those individuals who would not have medically improved since their last evaluation but whose benefits would be terminated under current law and regulations. Of those projected to lose benefits at the initial stage under current law, it is estimated that approximately 20 percent would not show medical improvement. However, of those 20 percent initially denied benefits under current law, it is projected that 85 percent would appeal and 75 percent of those who appeal would be continued on the rolls. Therefore, under current law, about 64 percent of the people losing benefits initially and whose disabilities have not improved would ultimately be continued on the DI rolls. Costs for this provision result from the continuation of benefits for the remaining 36 percent, who under current law, would not appeal the decision to end their benefits or who would not win their appeal and would be consequently dropped from the rolls. In 1985, the first full year this provision would be in effect, it is estimated that 6,400 people would be retained on the rolls as a result of this provision. The additional number of beneficiaries receiving DI as a result of this provision would fall to 2,000 by 1989 as CBO's estimate of the number of CDR's performed declines. The costs, including administrative expenses are estimated to rise from $22 million in 1984 to $133 million in 1989. This estimate, on the advice of staff of the Committee on Ways and Means, is assumed to be applied only to prospective cases. In SSI, only concurrent cases—those receiving both DI and

SSI—would be affected because no CDR's are planned for SSI only cases.

Multiple impairments

This provision would require SSA to consider whether the combination of the applicant's disabilities is severe enough to keep the individual from working at the "significant gainful activity" level in the case where no one impairment is considered severe enough to warrant benefit payments. The SSA estimates that about 500 additional cases per year would be added to the rolls as a result of this provision. This would increase DI costs by a range of less than $500,000 in 1984 to $15 million in 1989. In SSI, about 150 cases would be added initially, increasing SSI costs by a negligible amount in 1984 and by $3 million in 1989.

Face-to-face evidentiary hearings for reviews

This provision would require SSA to provide for face-to-face evidentiary hearings at the initial determination level for those terminated as a result of CDR's after January 1, 1985. There are no benefit increases shown for this provision. Under current law, beginning in 1984, face-to-face evidentiary hearings will occur at the first level of appeal. It is possible that more people will be retained on the rolls by allowing evidentiary hearings one step earlier. However, it is equally possible that fewer people will choose to appeal their decisions further because of the opportunity to present their cases at the initial level. Assuming that there is no change in the number of people who ultimately lose benefits, there would be no cost associated with this provision. However, there would be added administrative costs at the initial level due to a higher workload, although these costs would be offset somewhat by administrative savings because of fewer projected reconsiderations. The estimate of administrative costs assumes that each review takes 22 hours and that there would be some additional expenditures required for office space and travel.

Continued payment during appeal

This provision would provide for continued payment of disability benefits through the Administrative Law Judge (ALJ) level of appeal for those individuals who appeal SSA's decisions to end their benefits as a result of CDR's. The estimated costs, including administrative costs, are $25 million in 1984, $149 million in 1985, and declining to $31 million in 1989. The costs arise as a result of extra benefits paid to those who ultimately lose their appeal but do not repay the interim benefits as required under this provision. The estimate assumes that seven months of additional benefits are paid to each individual and that 15 percent of those who are finally terminated repay the extra benefits. This repayment is expected to occur in the year after the benefits are paid.

Medical personnel qualifications

This provision would require that a psychologist for a psychiatrist complete a medical evaluation of a claimant before the individual can be denied benefits. The SSA expects that about 1,000 individuals will be added to the rolls annually as a result of this

change in procedure. DI costs would range from $7 million in 1985 to $27 million in 1989, while SSI costs would total $7 million by 1989.

Vocational rehabilitation

This provision changes the regulations concerning benefit payments for individuals participating in vocational rehabilitation programs. The SSA estimates that about 300 individuals per year would be affected by this change. DI costs would range from negligible in 1984 to $8 million in 1989. SSI costs would be insignificant.

Compliance with court orders

This provision requires SSA to apply the decisions of the circuit courts of appeal to all beneficiaries residing within states within the circuit, until or unless the decision is overruled by the Supreme Court. This provision could substantially increase costs but these effects cannot be estimated since they would depend on the outcome of future court decisions.

Extension of section 1619a and 1619b

Sections 1619a and 1619b provide SSI and Medicaid benefits to disabled individuals who work and who would not otherwise be eligible for benefits because their earnings exceed the "substantial gainful activity" level. These sections, which expired on December 31, 1983, are extended by these amendments through June 30, 1986. Section 1619a is estimated to add 575 persons to the SSI rolls in 1984 and 950 by 1986. Section 1619b is estimated to add 8,300 persons to the Medicaid rolls in 1984 and 10,500 by 1986.

6. Estimated cost to State and local government: A number of the provisions of this bill would increase expenditures of state and local governments. The estimated net impact of the bill on state and local expenditures is less than $5 million a year.

The changes in SSI would increase state and local government costs because virtually all states supplement federal SSI benefits. By making more persons eligible for SSI benefits, state costs would increase. States are also affected by the added outlays in Medicaid because states finance a portion of the program. The current state financing share is 46 percent.

There could be some offsets to these added SSI and Medicaid costs to the extent that persons made eligible for DI and SSI by the bill might otherwise be eligible for general assistance or health care financed fully by states and localities. These potential offsets are not included in the cost estimate.

7. Estimate comparison: The Social Security Administration's latest estimate (January 13, 1984 and February 6, 1984) for this bill shows combined costs of about $6 billion over the six year period from 1984–1989. The SSA has higher estimates for the sections regarding medical improvement and for continued payment of benefits through the appeals process. The major differences arise because SSA assumes that a greater number of CDR's will be done each year, because the provision on medical improvements is assumed to be applied retroactively and because they assume a large increase in the number of appeals to the ALJ level, which would greatly increase administrative costs. CBO has followed the Com-

mittee's intent that the medical improvement provision be applied only prospectively.

8. Previous CBO estimate: None.

9. Estimate prepared by: Stephen Chaikind, Kelly Lukins, and Janice Peskin.

10. Estimate approved by:

C. G. NUCKOLS
(For James L. Blum,
Assistant Director for Budget Analysis).

B. Administration estimates

The Office of the Actuary, Social Security Administration, has estimated the impact of the bill on the disability trust fund over a 75-year period. Under II-B economic assumptions, the disability trust fund remains in actuarial balance. The following tables summarize the Administration's long-range and short-range estimates.

ESTIMATED COST OF THE SOCIAL SECURITY DISABILITY PROVISIONS, FISCAL YEAR 1984–88

[In millions]

Provision	Fiscal year—					Total, 1984–88
	1984	1985	1986	1987	1988	
OASDI benefit payments	$60	$390	$580	$650	$730	$2,410
OASDI administrative expenses	25	105	130	126	131	517
Medicare	25	45	65	80	95	310
Medical	13	21	21	15	20	90
SSI	3	2	9	19	23	50
Total	120	563	805	890	999	3,377

Note:—These estimates were made by the Office of the Actuary, Social Security Administration, based on the alternative II-B assumptions of the 1983 Trustees' Reports as revised in November 1983.

Source: Social Security Administration, Office of the Actuary, January 1984.

ESTIMATED LONG-RANGE FINANCIAL IMPACT OF THE SOCIAL SECURITY DISABILITY PROVISIONS

Bill section	Provision	Change in long-range OASDI actuarial balance (as percent of taxable payroll)
901	Standard of review for terminations of disability benefits	(1)
902	Study concerning evaluation of pain	(1)
903	Guidelines for disability determinations:	
	Multiple impairments	(1)
	Noncompetitive work	(1)
	Work evaluation in mental impairment cases [2]	(1)
904	Moratorium and revised criteria for mental impairment cases	(3)
905	Review procedure governing disability determinations affecting continued entitlement to disability benefits; demonstration projects relating to review of denials of disability benefit applications	(1)
906	Continuation of benefits through ALJ decisions	−0.01
907	Qualifications of medical professional evaluating mental impairments	(1)
908	Regulatory standards for consultative examinations	(1)
909	Administrative procedure and uniform standards	(1)
910	Compliance with certain court orders	(1)

ESTIMATED LONG-RANGE FINANCIAL IMPACT OF THE SOCIAL SECURITY DISABILITY PROVISIONS—Continued

Bill section	Provision	Change in long-range OASDI actuarial balance (as percent of taxable payroll)
911	Revision of vocational rehabilitation criteria	(1)
912	Advisory Council on Medical Aspects of Disability	(1)
913	Qualifying experience for appointment of certain staff attorneys to ALJ positions	(1)
	Total[4]	−.02

[1] Change in long-range OASDI actuarial balance is less than 0.005 percent of taxable payroll.
[2] Report language urges full "work evaluation" by a vocational expert in "borderline" mental impairment cases.
[3] The financial effect of this provision is attributed to the Secretary's initiative of June 7, 1983 for revising the criteria for evaluating mental impairment cases. Illustrative estimates of the change in the long-range OASDI actuarial balance for this revision are −0.03, −0.07, and −0.15 percent of taxable payroll based on the assumption that 10 percent, 25 percent of 50 percent of current mental impairment denials would be allowed (slightly higher percentages are assumed for current CDI terminations). At this time it is not known what provisions would be made to these criteria.
[4] Total includes the effect of interaction among sections.

Note: The estimates in this table are based on the alternative II–B assumptions of the 1983 Trustees Report.

Source: Social Security Administration, Office of the Actuary, Sept. 19, 1983.

V. Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

EVIDENCE, PROCEDURE, AND CERTIFICATION FOR PAYMENT

SEC. 205. (a) * * *

(b)(1) The Secretary is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this title. Any such decision by the Secretary which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Secretary's determination and the reason or reasons upon which it is based. Upon request by any such individual or upon request by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, surviving divorced father, husband, divorced husband, widower, surviving divorced husband, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Secretary has rendered, he shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse his findings of

fact and such decision. Any such request with respect to such a decision must be filed within sixty days after notice of such decision is received by the individual making such request. *Reviews of disability determinations on which decisions relating to continued entitlement to benefits are based shall be governed by the provisions of section 221(d)(2).* The Secretary is further authorized, on his own motion, to hold such hearings and to conduct such investigations and other proceedings as he may deem necessary or proper for the administration of this title. In the course of any hearing, investigation, or other proceeding, he may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Secretary even though inadmissible under rules of evidence applicable to court procedure.

[(2) In any case where—

[(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurnace benefits based on disability,

[(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and

[(C) as a consequence of the finding described in subparagraph (B), such individual is determined by the Secretary not to be entitled to such benefits,

any reconsideration of the finding described in subparagraph (B) in connection with a reconsideration by the Secretary (before any hearing under paragraph (1) on the issue of such entitlement) of his determination described in subparagraph (C), shall be made only after opportunity for an evidentiary hearing, with regard to the finding described in subparagraph (B), which is reasonably accessible to such individual. Any reconsideration of a finding described in subparagraph (B) may be made either by the State agency or the Secretary where the finding was originally made by the State agency, and shall be made by the Secretary where the finding was originally made by the Secretary. In the case of a reconsideration by a State agency of a finding described in subparagraph (B) which was originally made by such State agency, the evidentiary hearing shall be held by an adjudicatory unit of the State agency other than the unit that made the finding described in subparagraph (B). In the case of a reconsideration by the Secretary of a finding described in subparagraph (B) which was originally made by the Secretary, the evidentiary hearing shall be held by a person other than the person or persons who made the finding described in subparagraph (B).]

(2) Notwithstanding subsection (a)(2) of section 553 of title 5, United States Code, the rulemaking requirements of subsections (b) through (e) of such section shall apply to matters relating to benefits under this title. With respect to matters to which rulemaking requirements under the proceeding sentence apply, only those rules prescribed pursuant to subsections (b) through (e) of such section 553 and related provisions governing notice and comment rulemaking under subchapter II of chapter 5 of such title 5 (relating to administrative procedure) shall be binding at any level of review by a State

agency or the Secretary, including any hearing before an administrative law judge.

* * * * * * *

OTHER DEFINITIONS

SEC. 216. For the purposes of this title—

Spouse; Surviving Spouse

(a) * * *

* * * * * * *

Disability; Period of Disability

(i)(1) Except for purposes of sections 202(d), 202(e), 202(f), 223, and 225, the term "disability" means (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continous period of not less than 12 months, or (B) blindness; and the term "blindness" means central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of this paragraph as having a central visual acuity of 20/200 or less. The provisions of paragraphs (2)(A), 2(C), (3), (4), (5), and (6) of section 223(d) shall be applied for purposes of determining whether an individual is under a disability within the meaning of the first sentence of this paragraph in the same manner as they are applied for purposes of paragraph (1) of such section. Nothing in this title shall be construed as authorizing the Secretary or any other officer or employee of the United States to interfere in any way with the practice of medicine or with relationships between practioners of medicine and their patients, or to exercise any supervision or control over the administration or operation of any hospital.

(2)(A) * * *

* * * * * * *

(D) A period of disability shall end with the close of whichever of the following months is the earlier: (i) the month preceding the month in which the individual attains retirement age (as defined in section 216(l)), or (ii) the month preceding (I) the termination month (as defined in section 223(a)(1)), or, if earlier (II) the first month for which no benefit is payable by reason of section 223(e), where no benefit is payable for any of the succeeding months during the 15-month period referred to in such section. *A period of disability may be determined to end on the basis of a finding that the physical or mental impairment on the basis of which the finding of disability was made has ceased, does not exist, or is not disabling only if such finding is supported by substantial evidence described in paragraph (1), (2), or (3) of section 223(f). Nothing in the preceding sentence shall be construed to require a determination that a period of disability continues if evidence on the record at the*

time any prior determination of such period of disability was made, or new evidence which relates to such determination, shows that the prior determination was either clearly erroneous at the time it was made or was fraudulently obtained, or if the individual is engaged in substantial gainful activity. In any case in which there is no available medical evidence supporting a prior disability determination, nothing in this subparagraph shall preclude the Secretary, in attempting to meet the requirements of the preceding provisions of this subparagraph, from securing additional medical reports necessary to reconstruct the evidence which supported such prior disability determination.

* * * * * * *

DISABILITY DETERMINATIONS

SEC. 221. (a)(1) * * *

* * * * * * *

(d) [Any] *(a) Except in cases to which paragraph (2) applies, any* individual dissatisfied with any determination under subsection (a), (b), (c), or (g) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) with respect to decisions of the Secretary, and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2)(A) In any case where—

(i) an individual is a recipient of disability insurance benefits, child's, widow's, or widower's insurance benefits based on disability, mother's or father's insurance benefits based on the disability of the mother's or father's child who has attained age 16, or benefits under title XVIII based on disability, and

(ii) the physical or mental impairment on the basis of which such benefits are payable is determined by a State agency (or the Secretary in a case to which subsection (g) applies) to have ceased, not to have existed, or to no longer be disabling,

such individual shall be entitled to notice and oportunity for review as provided in this paragraph.

(B)(i) Any determination referred to in subparagraph (A)(A)(ii)—

(I) which has been prepared for issuance under this section by a State agency (or the Secretary) for the purpose of providing a basis for a decision of the Secretary with regard to the individual's continued rights to benefits under this title (including any decision as to whether an individual's rights to benefits are terminated or otherwise changed, and

(II) which is in whole or in part unfavorable to such individual,

shall remain pending until after the notice and opportunity for review provided in this subparagraph.

(ii) Any such pending determination shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence and stating such determination, the reason or reasons upon which such determination is based, the right to a review of such determination (including the right to make a personal appearance as provided in this subparagraph), the right to submit additional evidence prior to or during such review as provided in this

clause, and that, if such review is not requested, the individual will not be entitled to a hearing on such determination and such determination will be the disability determination upon which the final decision of the Secretary on entitlement will be based. Such statement of the case shall be transmitted in writing to such individual. Upon request by any such individual, or by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, husband, divorced husband, widower, surviving divorced husband, surviving divorced father, child, or parent, who makes a showing in writing that his or her rights may be prejudiced by such determination, he or she shall be entitled to a review by the State agency (or the Secretary in a case to which subsection (g) applies) of such determination, including the right of such individual to make a personal appearance, and may submit additional evidence for purposes of such review prior to or during such review. Any such request must be filed within 30 days after notice of the pending determination is received by the individual making such request. Any review carried out by a State agency under this subparagraph shall be made in accordance with the pertinent provisions of this title and regulations thereunder.

(iii) A review under this subparagraph shall include a review of evidence and medical history in the record at the time such disability determination is pending, shall examine any new medical evidence submitted or obtained for purposes of the review, and shall afford the individual requesting the review the opportunity to make a personal appearance with respect to the case at a place which is reasonably accessible to such individual.

(iv) On the basis of the review carried out under this subparagraph, the State agency (or the Secretary in a case to which subsection (g) applies) shall affirm or modify the pending determination and issue the pending determination, as so affirmed or modified, as the disability determination under section (a), (c), (g), or (h) (as applicable).

(C) Any disability determination described in subparagraph (A)(ii) which is issued by the State agency (or the Secretary) and which is in whole or in part unfavorable to the individual requesting the review shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the determination, the reason or reasons upon which the determination is based, the right (in the case of an individual who has exercised the right to review under subparagraph (B)) of such individual to a hearing under subparagraph (D), and the right to submit additional evidence prior to or at such a hearing. Such statement of the case shall be transmitted in writing to such individual and his or her representative (if any).

(D)(i) An individual who has exercised the right to review under subparagraph (B) and who is dissatisfied with the disability determination referred to in subparagraph (C) shall be entitled to a hearing thereon to the same extent as is provided in section 205(b) with respect to decisions of the Secretary on which hearings are required under such section, and to judicial review of the Secretary's final decision after such hearings as is provided in section 205(g). Nothing in this section shall be construed to deny an individual his or her right to notice and opportunity for hearing under section 205(b)

with respect to matters other than the determination referred to in subparagraph (A)(ii).

(ii) Any hearing referred to in clause (i) shall be held before an administrative law judge who has been duly appointed in accordance with section 3105 of title 5, United States Code.

* * * * * * *

[(i)] *(h)*(1) In any case where an individual is or has been determined to be under a disability, the case shall be reviewed by the applicable State agency or the Secretary (as may be appropriate), for purposes of continuing eligibility, at least once every 3 years, subject to paragraph (2); except that where a finding has been made that such disability is permanent, such reviews shall be made at such times as the Secretary determines to be appropriate. Reviews of cases under the preceding sentence shall be in addition to, and shall not be considered as a substitute for, any other reviews which are required or provided for under or in the administration of this title.

(2) The requirement of paragraph (1) that cases be reviewed at least every 3 years shall not apply to the extent that the Secretary determines, on a State-by-State basis, that such requirement should be waived to insure that only the appropriate number of such cases are reviewed. The Secretary shall determine the appropriate number of cases to be reviewed in each State after consultation with the State agency performing such reviews, based upon the backlog of pending reviews, the projected number of new applications for disability insurance benefits, and the current and projected staffing levels of the State agency, but the Secretary shall provide for a waiver of such requirement only in the case of a State which makes a good faith effort to meet proper staffing requirements for the State agency and to process case reviews in a timely fashion. The Secretary shall report annually to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to the determinations made by the Secretary under the preceding sentence.

(3) The Secretary shall report semiannually to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives with respect to the number of reviews of continuing disability carried out under paragraph (1), the number of such reviews which result in an initial termination of benefits, the number of requests for reconsideration of such initial termination or for a hearing with respect to such termination under subsection (d), or both, and the number of such initial terminations which are overturned as the result of a reconsideration or hearing.

(i) A determination under subsection (a), (c), (g), or (h) that an individual is not under a disability by reason of a mental impairment shall be made only if, before its issuance by the State (or the Secretary), a qualified psychiatrist or psychologist who is employed by the State agency or the Secretary (or whose services are contracted for by the state agency or the Secretary) has completed the medical portion of the case review, including any applicable residual functional capacity assessment.

(j) The Secretary shall prescribe regulations which set forth, in detail—

(1) the standards to be utilized by State disability determination services and Federal personnel in determining when a consultative examination should be obtained in connection with disability determinations;

(2) standards for the type of referral to be made; and

(3) procedures by which the Secretary will monitor both the referral processes used and the product of professionals to whom cases are referred.

Nothing in this subsection shall be construed to preclude the issuance, in accordance with section 533(b)(A) of title 5, United States Code, of interpretive rules, general statements of policy, and rules of agency organization relating to consultative examinations if such rules and statements are consistent with such regulations.

REHABILITATION SERVICES

Referral for Rehabilitation Services

SEC. 222. (a) * * *

* * * * * * *

Costs of Rehabilitation Services from Trust Funds

(d)(1) For purposes of making vocational rehabilitation services more readily available to disabled individuals who are—

(A) entitled to disability insurance benefits under section 223,

(B) entitled to child's insurance benefits under section 202(d) after having attained age 18 (and are under a disability),

(C) entitled to widow's insurance benefits under section 202(e) prior to attaining age 60, or

(D) entitled to widower's insurance benefits under section 202(f) prior to attaining 60,

to the end that savings accrue to the Trust Funds as a result of rehabilitating such individuals [into substantial gainful activity], there are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund each fiscal such sums as may be necessary to enable the Secretary to reimburse the State for the reasonable and necessary costs of vocational rehabilitation services furnished such individual (including services during their waiting periods), under a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.), [which result in their performance of substantial gainful activity which lasts for a continuous period of nine months] *(i) in cases where the furnishing of such services results in the performance by such individuals of substantial gainful activity for a continuous period of nine months, (ii) in cases where such individuals receive benefits as a result of section 225(b) (except that no reimbursement under this paragraph shall be made for services furnished to any individual receiving such benefits for any period after the close of such individual's ninth consecutive month of substantial gainful*

activity or the close of the month in which his or her entitlement to such benefits ceases, whichever first occurs), and (iii) in cases where such individuals, without good cause, refuse to accept vocational rehabilitation services or fail to cooperate in such a manner as to preclude their successful rehabilitation. The determination that the vocational rehabilitation services contributed to the successful return of such individuals to substantial gainful activity, *the determination that an individual, without good cause, refused to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation,* and the determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria formulated by him.

* * * * * * *

DISABILITY INSURANCE BENEFIT PAYMENTS

Disability Insurance Benefits

SEC. 223. (a)(1) * * *

* * * * * * *

Definition of Disability

(d)(1) * * *

(2) For purposes of paragraph (1)(A)

(A) * * *

* * * * * * *

(C) In determining whether an individuals physical or mental impairment or impairments are of such severity that he or she is unable to engage in substantial gainful activity, the Secretary shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity.

* * * * * * *

Standard of Review for Termination of Disability Benefits

(f) A recipient of benefits under this title or title XVIII based on the disability of any individual may be determined not to be entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(1) substantial evidence which demonstrates that there has been medical improvement in the individual's impairment or combination of impairments so that—

(A) the individual is now able to engage in substantial gainful activity, or

(B) if the individual is a widow or surviving divorced wife under section 202(e) or a widower a surviving divorced husband under section 202(f), the severity of his or her impairment or impairments is no longer deemed under regula-

tions prescribed by the Secretary sufficient to preclude the individual from engaging in gainful activity; or

(2) substantial evidence which—

(A) consists of new medical evidence and (in a case to which clause (ii) does not apply) a new assessment of the individual's residual functional capacity and demonstrates that, although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology so that—

(i) the individual is now able to engage in substantial gainful activity, or

(ii) if the individual is a widow or surviving divorced wife under section 202(e) or a widower or surviving divorced husband under section 202(f), the severity of his or her impairment or impairments is no longer deemed under regulations prescribed by the Secretary sufficient to preclude the individual from engaging in gainful activity; or

(B) demonstrates that, although the individual has not improved medically, he or she has undergone vocational therapy so that the requirements of clause (i) or (ii) of subparagraph (A) are met; or

(3) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as disabling as it was considered to be at the time of the most recent prior decison that he or she was under a disability or continued to be under a disability, and that therefore—

(A) the individual is able to engage in substantial gainful activity, or

(B) if the individual is a widow or surviving divorced wife under section 202(e) or a widower or surviving divorced husband under section 202(f), the severity of his or her impairment or impairments is not deemed under regulations prescribed by the Secretary sufficient to preclude the individual from engaging activity.

Nothing in this subsection shall be construed to require a determination that a recipient of benefits under this title or title XVIII based on an individual's disability is entitled to such benefits if evidenced on the record at the time any prior determination of such entitlement to disability was made, or new evidence which relates to that determination, shows that the prior determination was either clearly erroneous at the time it was made or was fraudulently obtained, or if the individual is engaged in substantial gainful activity. In any case in which there is no available medical evidence supporting a prior disability determination, nothing in this subsection shall preclude the Secretary, in attempting to meet the requirements of the preceding provisions of this subsection, from securing additional medical reports necessary to reconstruct the evidence which supported such prior disability determination. For purposes of this subsection, a benefit under this title is based on an individual's disability if it is a disability insurance benefit, a child's, widow's, or widower's insurance benefit based on disability, or a mother's or fa-

ther's insurance benefit based on the disability of the mother's or father's child who has attained age 16.

Continued Payment of Disability Benefits During Appeal

(g)(1) In any case where—

(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and as a consequence such individual is determined not to be entitled to such benefits, and

(C) as timely request [for a hearing under section 221(d), or for an administrative review prior to such hearing] *for review under section 221(d)(2)(B) or for a hearing under section 221(d)(2)(D)* is pending with respect to the determination that he is not so entitled,

such individual may elect (in such manner and form and within such time as the Secretary shall by regulations prescribe) to have the payment of such benefits, [and the payment of any other benefits under this Act based on such individual's wages and self-employment income (including benefits under title XVIII)], *the payment of any other benefits under this title based on such individual's wages and self-employment income, the payment of mother's or father's insurance benefits, to such individual's mother or father based on the disability of such individual as a child who has attained age 16, and the payment of benefits under title XVIII based on such individual's disability,* continued for an additional period beginning with the first month beginning after the date of the enactment of this subsection for which (under such determination) such benefits are no longer otherwise payable, and ending with the earlier of (i) the month preceding the month in which a decision is made after such a hearing, *or* (ii) the month preceding the month in which no such request for [a hearing or an administrative review] *review or a hearing* is pending [, or (ii) June 1984].

* * * * * * *

(3) The provisions of paragraphs (1) and (2) shall apply with respect to determinations (that individuals are not entitled to benefits) [which are made—

(A) on or after the date of the enactment of this subsection, or prior to such date but only on the basis of a timely request for a hearing under section 221(d), or for an administrative review prior to such hearing, and

(B) prior to December 7, 1983.] *which are made on or after the date of the enactment of this subsection, or prior to such date but only on the basis of a timely request for a hearing under section 221(d), or for an administrative review prior to such hearing.*

[EFFECTIVE AFTER DECEMBER 31, 1984]

(3) The provisions of paragraphs (1) and (2) shall apply with respect to determinations (that individuals are not entitled to benefits) which are made—

(A) on or after the date of the enactment of this subsection, or prior to such date but only on the basis of a timely request for [a hearing under section 221(d), or for an administrative review prior to such hearing,] review under secion 221(d)(2)(B) or for a hearing under section 221(d)(2)(D), and

(B) prior to December 7, 1983.

* * * * * * *

COMPLIANCE WITH COURT OF APPEALS DECISION

Sec. 234. (a) Except as provided in subsection (b), if, in any decision in a case to which the Department of Health and Human Services or an officer or employee thereof is a party, a United States court of appeals—

(1) interprets a provision of this title or of any regulation prescribed under this title, and

(2) requires such Department or such officer or employee to apply or carry out the provision in a manner which varies from the manner in which the provision is generally applied or carried out in the circuit involved,

the Secretary shall acquiesce in the decision and apply the enterpretation with respect to all individuals and circumstances covered by the provision in the circuit until a different result is reached by a ruling by the Supreme Court of the United States on the issue involved or by a subsequently enacted provision of Federal law.

(b) Acquiescence shall not be required under subsection (a) during the pendency of any direct appeal of the case by the Secretary under section 1252 of title 28, United States Code, or any request for review of the case by the Secretary under section 1254 of such title if such direct appeal or request for review is filed during the period of time allowed for such filing. If the Supreme Court finds that the requirements for the direct appeal under such section 1252 have not been met or denies a request for review under such section 1254, the Secretary shall resume acquiescence in the decision of the court of appeals in accordance with subsection (a) from the date of such finding or denial.

* * * * * * *

TITLE VII—ADMINISTRATION

* * * * * * *

SEC. 704. The Secretary shall make a full report to Congress, within one hundred and twenty days after the beginning of each regular session, of the administration of the functions with which he is charged under this Act. *Each such report shall contain a comprehensive description of the current status of the disability insurance program under title II and the program of benefits for the blind and disabled under title XVI (including, in the case of the reports made in 1984, 1985, and 1986, any advice and recommenda-*

tions provided to the Secretary by the Advisory Council on Medical Aspects of Disability, with respect to disability standards, policies, and procedures, during the preceding year). In addition to the number of copies of such report authorized by other law to be printed, there is hereby authorized to be printed not more than five thousand copies of such report for use by the Secretary for distribution to Members of Congress and to State and other public or private agencies or organizations participating in or concerned with the social security program.

* * * * * * *

TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

* * * * * * *

PART A—DETERMINATION OF BENEFITS

* * * * * * *

MEANING OF TERMS

AGED, BLIND, OR DISABLED INDIVIDUAL

SEC. 1614. (a)(1) * * *

* * * * * * *

(3)(A) * * *

* * * * * * *

(G) In determining whether an individual's physical or mental impairment or impairments are of such severity that he or she is unable to engage in substantial gainful activity, the Secretary shall consider the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity.

* * * * * * *

(5) A recipient of benefits based on disability under this title may be determined not be to entitled to such benefits on the basis of a finding that the physical or mental impairment on the basis of which such benefits are provided has ceased, does not exist, or is not disabling only if such finding is supported by—

(A) substantial evidence which demonstrates that there has been medical improvement in the individual's impairment or combination of impairments so that the individual is now able to engage in substantial gainful activity; or

(B) substantial evidence (except in the case of an individual eligible to receive benefits under section 1619) which—

(i) consists of new medical evidence and a new assessment of the individual's residual functional capacity and demonstrates that, although the individual has not improved medically, he or she is nonetheless a beneficiary of advances in medical or vocational therapy or technology so that the individual is now able to engage in substantial gainful activity, or

(ii) demonstrates that, although the individual has not improved medically, he or she has undergone vocational therapy so that he or she is now able to engage in substantial gainful activity; or

(C) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual's impairment or combination of impairments is not as disabling as it was considered to be at the time of the most recent prior decision that he or she was under a disability or continued to be under a disability, and that therefore the individual is able to engage in substantial gainful activity.

Nothing in this paragraph shall be construed to require a determination that a recipient of benefits under this title based on disability is entitled to such benefits if evidence on the record at the time any prior determination of such entitlement to benefits was made, or new evidence which relates to that determination, shows that the prior determination was either clearly erroneous at the time it was made or was fraudulently obtained, or if the individual (unless he or she is eligible to receive benefits under section 1619) is engaged in substantial gainful activity. In any case in which there is no available medical evidence supporting a prior determination of disability nothing in this paragraph shall preclude the Secretary, in attempting to meet the requirements of the preceding provisions of this paragraph, from securing additional medical reports necessary to reconstruct the evidence which supported such prior determination.

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REHABILITATION SERVICES FOR BLIND AND DISABLED INDIVIDUALS

SEC. 1615. (a) * * *

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(d) The Secretary is authorized to reimburse to the State agency administering or supervising the administration of a State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act the costs incurred under such plan in the provision of rehabilitation services to individuals who are referred for such services pursuant to subsection (a) [if such services result in their performance of substantial gainful activity which lasts for a continuous period of nine months] *(1) in cases where the furnishing of such services results in the performance by such individuals of substantial gainful activity for continuous periods of nine months, (2) in cases where such individuals are determined to be no longer entitled to benefits under this title because the physical or mental impairments on which the benefits are based have ceased, do not exist, or are not disabling (and no reimbursement under this subsection shall be made for services furnished to any individual receiving such benefits for any period after the close of such individual's ninth consecutive month of substantial gainful activity or the close of the month with which his or her entitlement to such benefits ceases, whichever first occurs), and (3) in cases where such individuals, without good cause, refuse to accept vocational rehabilitation services or fail to cooperate in such a manner as to preclude*

their successful rehabilitation. The determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria determined by him in the same manner as under section 222(d)(1).

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BENEFITS FOR INDIVIDUALS WHO PERFORM SUBSTANTIAL GAINFUL ACTIVITY DESPITE SEVERE MEDICAL IMPAIRMENT

SEC. 1619. (a) * * *

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(c) The Secretary of Health and Human Services and the Secretary of Education shall jointly develop and disseminate information, and establish training programs for staff personnel, with respect to the potential availability of benefits and services for disabled individuals under the provisions of this section. The Secretary of Health and Human Services shall provide such information to individuals who are applicants for and recipients of benefits based on disability under this title and shall conduct such programs for the staffs of the District offices of the Social Security Administration. The Secretary of Education shall conduct such programs for the staffs of the State Vocational Rehabilitation agencies, and in cooperation with such agencies shall also provide such information to other appropriate individuals and to public and private organizations and agencies which are concerned with rehabilitation and social services or which represent the disabled.

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PART B—PROCEDURAL AND GENERAL PROVISIONS

PAYMENTS AND PROCEDURES

Payment of Benefits

SEC. 1631. (a)(1) * * *

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(7)(A) In any case where—

(i) an individual is a recipient of benefits based on disability or blindness under this title,

(ii) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and as a consequence such individual is determined not to be entitled to such benefits, and

(iii) a timely request for review or for a hearing is pending with respect to the determination that he is not so entitled,

such individual may elect (in such manner and form and within such time as the Secretary shall by regulations prescribe) to have the payment of such benefits continued for an additional period beginning with the first month beginning after the date of the enactment of this paragraph for which (under such determination) such benefits are no longer otherwise payable, and ending with the earlier of (I) the month preceding the month in which a decision is made after

such a hearing, or (II) the month preceding the month in which no such request for review or a hearing is pending.

(B)(i) If an individual elects to have the payment of his benefits continued for an additional period under subparagraph (A), and the final decision of the Secretary affirms the determination that he is not entitled to such benefits, any benefits paid under this title pursuant to such election (for months in such additional period) shall be considered overpayments for all purposes of this title, except as otherwise provided in clause (ii).

(ii) If the Secretary determines that the individual's appeal of his termination of benefits was made in good faith, all of the benefits paid pursuant to such individual's election under subparagraph (A) shall be subject to waiver consideration under the provisions of subsection (b)(1).

(C) The provisions of subparagraphs (A) and (B) shall apply with respect to determinations (that individuals are not entitled to benefits) which are made on or after the date of the enactment of this paragraph, or prior to such date but only on the basis of a timely request for review or for a hearing.

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Procedures; Prohibitions of Assignments; Representation of Claimants

(d)(1) The provisions of section 207 and subsections (a) *(b)(2)*, (d), (e), and (f) of section 205 shall apply with respect to this part to the same extent as they apply in the case of title II.

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ADMINISTRATION

SEC. 1633. (a) * * *

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(c) Section 234 shall apply with respect to decisions of United States courts of appeals involving interpretations of provisions of this title or of regulations prescribed under this title (and requiring action with respect to such provisions) in the same manner and to the same extent as it applies with respect to decisions involving interpretations of provisions of title II or of regulations prescribed thereunder (and requiring action with respect to such provisions).

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PUBLIC LAW 97-455

AN ACT To amend Internal Revenue Code of 1954 to reduce the rate of certain taxes paid to the Virgin Islands on Vigin Islands source income, to amend the Social Security Act to provide for a temporary period that payment of disability benefits may continue through the hearing stage of the appeals process, and for other purposes.

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[SEC. 4. EVIDENTIARY HEARINGS IN RECONSIDERATIONS OF DISABILITY BENEFIT TERMINATIONS.

[(a) IN GENERAL.—Section 205(b) of the Social Security Act is amended

[(1) by inserting "(1)" after "(b)"; and

[(2) by adding at the end thereof the following new paragraph:

["(2) In any case where—

["(A) an individual is a recipient of disability insurance benefits, or of child's, widow's, or widower's insurance benefits based on disability,

["(B) the physical or mental impairment on the basis of which such benefits are payable is found to have ceased, not to have existed, or to no longer be disabling, and

["(C) as a consequence of the finding described in subparagraph (B), such individual is determined by the Secretary not to be entitled to such benefits.

any reconsideration of the finding described in subparagraph (B), in connection with a reconsideration by the Secretary (before any hearing under paragraph (1) on the issue of such entitlement) of his determination described in subparagraph (C), shall be made only after opportunity for an evidentiary hearing, with regard to the finding described in subparagraph (B), which is reasonably accessible to such individual. Any reconsideration of a finding described in subparagraph (B) may be made either by the State agency or the Secretary where the finding was originally made by the State agency, and shall be made by the Secretary where the finding was originally made by the Secretary. In the case of a reconsideration by a State agency of a finding described in subparagraph (B) which was originally made by such State agency, the evidentiary hearing shall be held by an adjudicatory unit of the State agency other than the unit that made the finding described in subparagraph (B). In the case of a reconsideration by the Secretary of a finding described in subparagraph (B) which was originally made by the Secretary, the evidentiary hearing shall be held by a person other than the person or persons who made the finding described in subparagraph (B).".

[(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to reconsiderations (of findings described in section 205(b)(2)(B) of the Social Security Act) which are requested on or after such date as the Secretary Health and Human Services may specify, but in any event not later than January 1, 1984.

[SEC. 5. CONDUCTS OF FACE-TO-FACE RECONSIDERATIONS IN DISABILITY CASES.

[The Secretary of Health and Human Services shall take such steps as may be necessary or appropriate to assure public understanding of the importance the Congress attaches to the face-to-face reconsiderations provided for in section 205(b)(2) of the Social Security Act (as added by section 4 of this Act). For this purpose the Secretary shall—

[(1) provide for the establishment and implementation of procedures for the conduct of such reconsiderations in a manner which assures that beneficiaries will receive reasonable notice and information with respect to the time and place

of reconsideration and the opportunities afforded to introduce evidence and be represented by counsel; and

[(2) advise beneficiaries who request or are entitled to request such reconsiderations of the procedures so establishd, of their opportunities to introduce evidence and be represented by counsel at such reconsiderations, and of the importance of submitting all evidence that relates to the question before the Secretary or the State agency at such reconsideration.]

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SECTION 201 OF THE SOCIAL SECURITY DISABILITY AMENDMENTS OF 1980

BENEFITS FOR INDIVIDUALS WHO PERFORM SUBSTANTIAL GAINFUL ACTIVITY DESPITE SEVERE MEDICAL IMPAIRMENT

SEC. 201. (a) * * *

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(d) The amendments made by subsections (a) and (b) shall become effective on January 1, 1981, but [shall remain in effect only for a period of three years after such effective date.] *shall remain in effect only through June 30, 1986.*

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